Abt Associates Inc.

National Medicare Education Program Assessment: Medicare Managed Care Markets and Information in Six Communities 1998-2001

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Final Report

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1.0 Introduction and Overview

This report looks at managed care markets and information in the six communities that have been monitored by Abt Associates since 1998, when the NMEP was initiated, as part of its *National Medicare Education Program Assessment*. These communities include Dayton OH, Eugene OR, Olympia WA, Sarasota FL, Springfield MA, and Tucson AZ. These six communities were selected because, among other criteria, they represented a wide range of experience with Medicare managed care.

Monitoring the managed care marketplaces and reactions of information suppliers at our study sites gives us a view of what kinds of information about managed care are needed and what is available under varying circumstances. By understanding the varying contexts among our study sites we gain a view of how NMEP policies and initiatives are experienced by beneficiaries and the information providers who serve them. Local information providers potentially play a critical role in dissemination of information about managed care, because much of what is important for beneficiaries to know about managed care choices is, in fact, local in nature. During our three years of monitoring, we have observed the reactions of local information providers to significant changes in the managed care marketplaces in our sites, and watched as they have evolved, or not, in terms of skills, capacities, and interest in gathering and communicating information about Medicare managed care. We have tracked the evolution of the "partnership" among CMS, state key partners, and local information providers in each of the study communities in order to understand what role CMS currently has in developing local information providers and in supplying them with the information about managed care that they need. Our case study monitoring has illustrated some of the challenges faced by the Medicare program in offering a Medicare coverage option that is dependent on the market—both on the strategic business decisions of Medicare managed care plans as well as the decisions of healthcare providers about participation in these organizations. Understanding these local Medicare information structures, their needs and abilities, and potential for development, provides useful perspectives for planning regarding future phases of the NMEP.

The purpose of the report is to continue a view begun last year of the Medicare managed care marketplaces in our study sites, to understand the demands for Medicare information, and the types of responses made by information suppliers. Chapter Two presents a summary of recent changes in the managed care marketplace in our six study sites. (Details of the managed care changes in each community are found in Appendix A.) Chapter Three includes an update on beneficiary behavior as shown in managed care enrollment and switching patterns, based on analyses of the CMS Enrollment Data Base. Chapter Four discusses the current status of provision of information about Medicare managed care at the sites. A brief summary of results from our National Medicare Education Program (NMEP) Community Monitoring Survey on beneficiaries' information-seeking about managed care is presented next. The final chapter discusses implications for provision of managed care information.

One important aspect of the current environment is that the pace of change itself has accelerated. Network disruptions, such as provider terminations, which are happening more frequently at our sites, can happen at any time. Even plan terminations and benefit changes,

which happen just once a year, are announced mid-year, giving beneficiaries just six months or nine months of stability with a benefit plan before changes begin again.

Methodology

This report is based on a number of data sources:

- ***In-depth discussions with local Medicare information suppliers and other experts*** **in our six study communities as well as knowledgeable state officials and staff at CMS Regional Offices. We have spoken with these contacts before and/or after the Fall NMEP campaigns since 1998. These discussions form the basis for our descriptions of the critical changes and events taking place in the managed care marketplaces and the information responses to these changes in our study sites throughout this report.**

- **Results of our annual *NMEP Community Monitoring Survey* of Medicare beneficiaries are the basis for the discussion about information demand in Chapter 5.**

- **Data from the *CMS Enrollment Data Base* are used in our analysis of beneficiary enrollment and switching patterns at the sites. Throughout this report, general enrollment data includes aged and disabled beneficiaries but not beneficiaries with ESRD. Note, however that the "switching" analyses in Section 3.2, which focus on a cohort of beneficiaries continuously resident in the sites since 1998, include only aged beneficiaries.[1]**

- **We reviewed the *main local newspaper* for each of our sites and well-known monthlies targeted to seniors in Sarasota and Tucson for the period September 2000 – January 2001 for information about topics relevant to the NMEP, including managed care issues.[2]**

- **Information from *Medicare Compare and plan marketing materials* was used in analysis of plan benefit changes from 1998 to the present.**

- ***In-depth discussions with 31 new Medicare enrollees*** **about their transition to Medicare and their use of information in making initial coverage choices in Springfield and Tucson were used to supplement analysis of beneficiary attitudes toward managed care.**

Details about our use of the Enrollment Data Base and the NMEP Community Monitoring Survey are found in Appendix F.

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[1] **February data are collected from the EDB in March in order to minimize inaccuracies caused by reporting lags. However, it is possible that some reporting lags exceed a month.**

[2] **See our report on Information Supply for a full description of the project and our findings. Copies of newspaper articles about Medicare managed care at our sites are available on request.**

1.1 Key Findings

- ***Enrollment in managed care decreased slightly in our study sites during the past year.***

Much of this decline was associated with managed care plans that terminated their contracts with Medicare. About 10,000 beneficiaries in Sarasota, with no managed care choice, returned to Original Medicare, while about 20% of those who were involuntarily disenrolled in the other sites returned to Original Medicare, even though there were managed care choices remaining.

- ***The managed care environment has continued to change in almost all our sites. During the past year, Medicare managed care choices have declined in four sites, benefits have been reduced and cost sharing increased, and significant network disruptions have taken place.***

The most striking change took place in Sarasota, FL, where the two remaining managed care plans terminated their Medicare contracts at the end of 2000. Plan terminations also took place in Dayton, OH, Olympia, WA, and Tucson, AZ. In both Tucson and Olympia, a remaining plan curtailed enrollment, further limiting beneficiaries' access to managed care. Over the three-year study period, the number of managed care plans available in our sites has declined from 29 to 13. In 1998, when our monitoring began, each site had at least four managed care plans available to beneficiaries. Now, in 2001, two plans are offered in two sites, three plans in three sites, and one site has been abandoned by Medicare managed care plans.

The remaining managed care plans reduced benefits, especially prescription coverage, and increased member cost-sharing through raises in premiums and service copayments. Managed care plans reduced prescription coverage for the year 2000 in all sites where that benefit was offered and continued to reduce benefits for the 2001 benefit year. Plans reduced coverage in various ways-by raising copayments, lowering coverage limits, or eliminating coverage of brand name medications altogether. Prescription coverage by the Medicare managed care plans at our sites has changed significantly since 1998. At that time, beneficiaries could find a plan with a $2000 prescription benefit in all four sites where the prescription benefit was offered. In 2001, only one plan in one site (Tucson) continues to offer even a $1000 benefit that includes coverage of brand name medications.

Network instability continued to affect some sites. In Tucson, the instability among hospitals and physicians that was reported in last year's report continued into 2000, because, according to local contacts, local providers now have greater bargaining power with plans. Network instability emerged as a new issue in Olympia. The financial failures of two large physician group practices and shortages of primary care physicians in the community affected one Medicare managed care plan, which subsequently instituted capacity limits, effectively reducing beneficiaries' managed care choices to a single plan.

- ***One important effect of changes in the managed care environments during the past three years has been to make the decisions about choices available to beneficiaries more complex.***

At the beginning of our case study, many information providers and beneficiaries at our sites had relatively simple perceptions about what was important when making a decision about whether to select a managed care plan. Their emphasis was on network adequacy (often seen

as simply as "whether your doctor (or hospital) is in the plan"), the acceptability of the constraints of a PCP gatekeeper, and the financial advantages of managed care in comparison to the cost of purchasing a Medigap supplement to establish comprehensive Medicare coverage.

The changes that have taken place in the managed care environments since 1998 highlight the very fundamental differences between the options of Original Medicare and managed care that many beneficiaries and information providers were not aware of just three years ago. The experience of plan terminations in most of our sites has heightened many beneficiaries' awareness that plans make the decision about Medicare participation annually and the financial consequences they might face in purchasing Medigap coverage if a plan exits. Several plan representatives among our site contacts reported that prospective members at sales meetings are now asking about the stability of the plan and its intention to stay in the service area. Beneficiaries also want to know why one plan might stay, if another one had left because it claimed it couldn't afford to provide services.

According to some site contacts, some beneficiaries are increasingly concerned about provider networks' instability — fearing its effects on their access to health services and on the future availability of plans — as well as concerns about cost increases. Also, as cost-sharing requirements increase and benefits are reduced among plans, it becomes more difficult for beneficiaries, as well as information providers, to compare the relative value of benefits for individual situations, both among managed care plans and between the managed care option and Original Medicare.

- ***Several types of evidence from the case study, taken together, suggest that the systems for providing access to useful information about managed care in local markets are working, though improvements are still needed.***

It is difficult to answer the question of effectiveness directly since metrics for measuring it are limited. However, data from our assessment provides some insight. We know that the systems of information supply (principally by the SHIPs) have been able to accommodate the complex and urgent local information issues required by extensive involuntary disenrollments and other new issues. We also know that the vast majority of information about plan choice is still provided to beneficiaries by plans, with only 6-9 percent of beneficiaries using community or public information resources about managed care. We also know that the six study sites do vary in terms of the volume of information demanded by beneficiaries about managed care, suggesting that some outreach efforts may still be able to be improved; in Springfield, for example, where a longstanding and rather extensive program of community outreach has been conducted, the beneficiary demand for community sources of managed care information is about twice as high as the other five sites. We also examined beneficiary satisfaction levels, and found that among users of managed care information, about 80 percent found the information they received (from both private and public sources) to be useful or very useful; an encouraging finding, but still showing room for improvement. We also examined the satisfaction levels of new enrollees in 2000 as a group (all of whom must make a plan choice); they were much more likely to access information about managed care choice than other aged beneficiaries, and among those who did access such information, as with other beneficiaries, about 80 percent found the information useful or very useful. As with the other beneficiaries, the effectiveness of

the information received could be improved; about half of the 80 percent found the information they received very useful, and about half found the information only somewhat useful.

- ***The provision of information about managed care has also become more challenging. Among key partners, the state SHIP programs have taken the lead in gathering information about important market changes and establishing information strategies to keep local SHIPs informed. However, local SHIP programs at our sites appear to vary greatly in terms of their information responses to managed care market changes.***

Our multi-year monitoring of the sites has witnessed a trend of some information providers to now include in their discussions more information about Medicaid, state prescription drug benefits, eligibility for VA benefits, eligibility for QMB/SLMB as well as more details about managed care plans such as networks, formularies, provider access, capacity limits, and the like.

Last year we reported that the shifts in the managed care environment have the potential for making new demands on local Medicare information providers because of the speed with which they happen. Other changes in Medicare, such as the expansion of preventive benefits, can be rolled out in a communications campaign that takes months; in situations like that, once decided, the basic facts don't change over time, and the main challenge is reaching the targeted audience. In contrast, managed care marketplace changes present a different challenge for information providers (local or otherwise). Such changes have taken place frequently in our study sites, sometimes occur "off-cycle," are often specific to single geographic areas (e.g., premium increases and provider terminations) and are more dynamic, in that the facts often shift over time. Some information providers recognized a need for mechanisms that can quickly disseminate information. We observed in our case study discussions this year the value of some efforts made by CMS CO and Regional Offices to communicate information about managed care market changes to local information providers.

Among our sites, the state SHIP programs are recognized as taking the central role in gathering, prioritizing, and then distributing information about marketplace changes to local SHIP programs and often to other of CMS's key partners in the state. However, local SHIP programs in our sites vary considerably in terms of their involvement in providing information regarding managed care. After tracking our sites for three years, it is apparent that arrangements between the SHIP program and the sponsoring organization seem to influence the information response to changes in the managed care marketplace. Organizations that provide knowledgeable professional staff, and significant staff time, to the SHIP program seem to be able to respond more thoroughly to the challenges of managed care issues. SHIPs with little professional support and diffuse organizational arrangements seem less likely to have the skills and resources available to develop this capacity.

- ***Our study of managed care "switching behavior" at the case study sites continues to demonstrate that the switching behavior of beneficiaries is strongly affected by market conditions.***

Most beneficiaries in the cohort do not appear to be motivated to switch among managed care plans or return to Original Medicare unless they are affected by significant market changes,

such as plan terminations and possibly significant benefit or network changes. In Olympia and Eugene, our most stable sites in terms of managed care plan offerings, 73% and 79% of beneficiaries who had any experience in managed care during the study period are still in the same plan they were in at the beginning of the study. The experiences of many beneficiaries in Tucson, Dayton, and Springfield have been quite different. In those sites, 42%, 49%, and 60% of beneficiaries who have had any experience in managed care during the study are in the same plan they were in at the start.

- ***The commercial sources of information — managed care plans and insurance companies — continue to be those most used by respondents to find information about managed care.***

On average across the four waves of the survey, about 69% of managed care enrollees and 53%of those enrolled in Original Medicare turned to plans and insurance companies when they sought information about managed care. Those who sought information via personal contact (i.e., in-person or by telephone) named their doctors and doctors' office staff and friends or family members next. Few respondents reported using other sources, such as senior centers, SHIP counselors, Medicare offices, or SSA offices in this way. However, senior centers, SHIP programs, and Medicare were cited more often as sources of printed information about managed care than were doctors' offices or friends. These findings are unchanged from last year.

- ***Use of CMS information sources to find information on managed care, while low relative to commercial sources (plans and insurance companies), is increasing.***

Use of Medicare offices and helplines, the Medicare Handbook, and other printed information obtained from Medicare by beneficiaries to find managed care information increased from 7% during 1998 to 12% during 2000, with use among those in Original Medicare accounting for most of the rise. Increase in the use of printed information from Medicare is the key factor in these results.

2.0 Managed Care Enrollment and Plan Availability

This section describes the current Medicare managed care marketplaces in our sites, and how they have changed since our last report.[3] Tracking the evolution of these marketplaces over time provides insight into how the managed care choices available to beneficiaries change from year to year and some perspective as to the relative attractiveness of the plan choices.

During the past year, the number of Medicare beneficiaries enrolled in local managed care options across the six study sites has declined slightly. Much of this decline was associated with managed care plans that terminated their contracts with Medicare. The most striking change took place in Sarasota, FL, where the two remaining managed care plans terminated their Medicare contracts at the end of 2000, returning about 10,000 beneficiaries to Original Medicare without a managed care choice. Plan terminations also took place in Dayton, OH, Olympia, WA, and Tucson, AZ, and although beneficiaries in these communities had other managed care choices remaining, about 20% of the terminated plan enrollees elected to return to Original Medicare.[4]

Table 2.1 summarizes the changes in the managed care penetration rates and the number of managed care choices at our sites from the beginning of the study period to the present. Penetration has declined during the past year in all our sites, and has increased only in Olympia when compared to 1998 rates. Over the study period the number of Medicare managed care plans offered at our sites dropped from 29 to 13. In 1998, each site had at least four managed care plans available to beneficiaries. Now, in 2001, there is less competition in every market. One site has been abandoned by managed care plans, only two plans are offered in two sites, and three plans are offered in three sites. In most cases the departing plans had trailed others in the local market in terms of enrollment; the only exception was the exit of Humana Health Plan which was the dominant plan in the county at the time of its departure from Sarasota in 1998. No new plans have entered these communities during our study period. The Tucson and Sarasota markets have probably seen the most change. In Tucson, almost half of the community's Medicare population was enrolled in the seven managed care plans available in 1998. Now, two plans remain in the market. Medicare managed care was a relatively recent development in Sarasota when our study began, and all plans left the market by 2001.[5]

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[3] ***National Medicare Education Program: Medicare Managed Care Markets and Information in Six Communities 1998-2000.***

[4] **Based on CMS EDB data through February 2001.**

[5] **Abt's recent report, *Involuntary Disenrollment from Medicare Managed Care Plans: Experience of Beneficiaries in Six Communities*, studies this issue.**

Table 2.1
Medicare Managed Care Penetration and Number of Medicare Managed Care Plans by Study Site: 1998, 2000 and 2001

	Medicare Managed Care Penetration			Number of Medicare Managed Care Plans in Study Site		
Study Site	**1998**	**2000**	**2001**	**1998**	**2000**	**2001**
Dayton, OH	16.8%	16.5%	15.2%	4	3	2
Eugene, OR	45.9%	45.0%	41.7%	4	3	3
Olympia, WA	37.2%	41.4%	38.8%	4	4	3
Sarasota, FL	12.1%	11.3%	N/A*	4	2	0
Springfield, MA	21.3%	21.6%	21.3%	6	3	3
Tucson, AZ	48.8%	49.1%	45.2%	7	4	2

Source: **CMS Enrollment Data Base (EDB) as of May 1998, February 2000, and March 2001. Penetration rate is based on those enrolled in a Medicare managed care plan (MMCP). Note that some beneficiaries are enrolled in MMCPs that are not publicly sold in the county, such as MMCPs from former employers.**
Base: Aged and disabled beneficiaries resident in the six study sites in May 1998, in February 2000, and February 2001.
*** No managed care plans are available as of 1/1/01 at the Sarasota site.**

Some of the features that attracted beneficiaries to managed care in the past are eroding. Managed care plans reduced benefits and increased cost-sharing by members for the 2000 calendar year; that trend continued into 2001. Not only are there fewer managed care choices at our sites, but those that do remain are offering less to beneficiaries by reducing benefits and increasing charges to members. Table 2.2 provides a summary of how benefits and costs have changed among the plans at our sites. Enrollees are required to pay more out-of-pocket to gain access to plan services and to compensate for services that are no longer covered.

Table 2.2 Market Changes 2000-2001 in the Six Study Sites

	Plan Terminations Effective 1/1/01	Increases in Beneficiary Charges; Benefit Reductions- Effective 1/1/01	Reductions in Prescription Coverage- Effective 1/1/01	Capacity Limits (C.L.)/Closed Enrollments (C.E.)*	Network Instability
Dayton, OH (4 counties)	1 plan (2 counties affected)	All plans (2)	Plans in 3 of the study counties; the plan in the 4th county has no prescription benefit	1 product in 1 county (C.L.)	---
Eugene, OR	---	All plans (3)	N/A – Plans do not include a prescription benefit	---	---
Olympia, WA	1 plan	All plans (3)	N/A – Plans do not include a prescription benefit	1 plan (C.L.)	✔
Sarasota, FL**	2 plans – Abandoned County designation	N/A	N/A	N/A	N/A
Springfield, MA	---	All plans (3)	All plans	---	✔
Tucson, AZ	2 Plans	All plans (2)	All plans	1 plan (C.E.)	✔

***Sources*: Medicare Compare, plan marketing materials, case study discussions regarding network instability.**
***Capacity limits were announced in the Fall, but Medicare Compare directed beneficiaries to check with plans. Although one plan in the Dayton site was listed as having capacity limits in late 2000, by early 2001 the designation was lifted. Closed enrollment was effective early 2001.**
****No managed care plans are available in Sarasota as of 1/1/01.**

The types of changes made to plan benefits and charges for 2001 included:

- **Across all sites, plans that required monthly premiums in 2000 raised those premiums for the 2001 calendar year. Most monthly premium increases were around $10 - $15; however one plan at our Springfield site raised its premium three-fold, from $25 to $105, which has since been rolled back to $95/month, using BIPA funds. Plans in Eugene and Olympia also used BIPA funds to reduce premiums.**

- **Many plans raised co-payment amounts for office visits; physician co-payments range from $5 to $20 a visit and the increases were generally in increments of $5.**

- **Plans introduced co-payments for hospital stays in 2000, and in 2001 some plans modified that approach by instituting a co-payment for each day of hospital care, rather than a simple co-payment for each stay. One Tucson plan introduced a "tiered" system of co-payments for hospital care. That is, rather than refusing coverage for members in non-network hospitals, the plan charges members a co-payment for non-emergency admissions at those hospitals. Given the difficulty plans are having contracting with Tucson hospitals, this is one approach that gives members wider hospital access, for members willing to pay for it.**

Plans made changes to the prescription drug benefit in the four sites where that benefit has been offered, such as raising copayments, reducing coverage limits, and eliminating coverage for brand name medications. Plans in Eugene and Olympia have not covered prescription drugs, explaining to their members that the AAPCC rates were not high enough to allow it.

All plans that offered coverage for prescription drugs when our study began reduced coverage dramatically for the 2000 benefits. In 2001, benefits were reduced again, but not so drastically. Table 2.3 below shows how prescription coverage benefits for the larger plans available in the communities have changed since our monitoring of the six communities began. The differences are quite striking. For example, beneficiaries could find a plan with $2000 coverage in all four sites in 1998. In 2001, only one plan (United HealthCare, in Tucson) continues to offer even a $1000 benefit that includes brand name drugs.

As time goes on the differentiation among local plans around major benefits and member charges seems to diminish. While there is considerable variation among the sites as to the mechanisms that plans use to achieve the cost-reductions they seek, such as increases in co-payments or premiums, there seems to be less variation in coverage within individual sites, perhaps reflecting competitive pressures. For example, in Olympia, both managed care companies introduced premiums in 2000, and raised them in 2001. In Tucson, for 2001, both remaining plans maintained zero premium products and eliminated coverage for brand-name drugs from those products' prescription benefits. In Dayton, both remaining plans now require co-payments for each day of a hospital stay. (See the site-specific tables in Appendix 1 for details on how benefits and costs in local plans were changed for the 2001 benefit year.)

Table 2.3
Changes in the Prescription Benefit in Four Study Sites[1] 1998 – 2001

	1998 Benefits Coverage and Co-payments*	2001 Benefits
Dayton		
Anthem (Community Health Insurance)	$1000/ year $5/$15 co-payments	$100/quarter for brand name drugs, unlimited coverage for generic $12/$35 co-payments
United Health Care	$600/year $10/$25 co-payments	$300/year for all prescription drugs $12/$50 co-payments
PacifiCare	$1000/year $6/$30 co-payments	---terminated---
Aetna US Health Care	4 products available $1000-$2000/year $10/$25 co-payments Premiums: est. $10-107/month	---terminated---
Sarasota		
United Health Care	$1000/year $5/$10 co-payments	---terminated---
Aetna US Healthcare	2 products available $1500-2500/year $12/12 co-payments	---terminated---
Humana Health Plan	$600/year $5/$15 co-payments	---terminated---
Springfield		
BCBSMA	Coverage available only through premium plan: $30/month Unlimited coverage $8/$15 co-payments	$150/quarter $8/$15 co-payments Premium: $95/month (reduced from $105 using BIPA funds)
Tufts Health Care	Coverage available only through premium plan: $74/month Unlimited coverage $8 co-payments	$150/quarter $8/$15 co-payments plus co-payment of $35 for brand name drugs not on formulary Premium: $45/month
Harvard Pilgrim Health Care	Coverage available only through premium plan: $71/month Unlimited coverage $8/$15 co-payments	---terminated---
Tucson		
PacifiCare	$2500 $7/$7 co-payments Unlimited coverage from formulary available for additional $5/month	2 products available -- Zero premium: unlimited generic only $25 premium: $1000 brand name**, unlimited generic; $10/$25 co-payments
Intergroup (HealthNet)	2 products available $1500-$3000 $8/$8 co-payments Unlimited generic after maximum met.	1 product only: Unlimited generic only $10 co-payment
United Health Care	$2500 $7/$15 co-payments	---terminated---
Cigna	2 products available: Up to $4000/year $6-$7/$12-$15 Co-payments	---terminated---

Sources: **Medicare Compare, 1998 and 2001; plan marketing materials 1998 and 2001.**
***Co-payment amounts are expressed as "co-payment for generic/co-payment for brand name" drugs.**
****Plan closed enrollment into this product in early 2001.**
[1]Plans in only four sites included prescription coverage.

Network instability was an issue for managed care plans in most sites in 2000. Instability of provider networks first emerged as an issue in Sarasota, Tucson, and Springfield in 1999, when important local hospitals and physician groups terminated or refused contracts with plans. In 2000, instability lessened in Springfield, although one tertiary hospital delayed renewing its contract with one plan, causing some uncertainty among residents in the surrounding area. However, instability continued as a major issue in Tucson, where, according to local experts, local providers now have greater bargaining power with plans. According to local contacts in Sarasota, where both plans exited as of January 1, 2001, some physicians who participated in the networks of those plans terminated their contracts before the end of 2000.

Also in 2000, two other sites, Olympia and Dayton, began to encounter difficulties. Since the beginning of our case study, Olympia had been one of the most stable managed care markets. However, in 2000, one plan in Olympia was affected by the financial failures of two major physician group practices as well as shortages of PCPs in the community, and subsequently instituted capacity limits. Although there were no active disruptions in 2000, local contacts in Dayton voiced concerns about future instability among networks, noting that local hospital providers were requesting fees that are higher than Medicare rates from plans, and pointed out that providers in Cincinnati and Columbus had succeeding in obtaining increased payments.

In Dayton, Eugene, Olympia, and Springfield, some plan representatives reported that the increased payments made to plans under BIPA will be allocated to raising provider payments in order to maintain adequate networks.

In some sites managed care plans have curtained enrollment and in others plans have reduced marketing activity. PacifiCare Secure Horizons in Olympia obtained and implemented a capacity limit[6] in October 2000. This action is likely to be very disruptive for beneficiaries who are newly interested in managed care in Thurston County. The only other large plan in the county, Group Health of Puget Sound, is a staff model, and, according to local experts, it primarily attracts beneficiaries who have been Group Health members prior to Medicare eligibility. Therefore, most Medicare beneficiaries without that experience have tended to select PacifiCare. In Tucson, PacifiCare Secure Horizons closed one product to new enrollments in January 2001. With that action, Medicare beneficiaries in Tucson temporarily lost access to the only product offering brand-name prescription coverage.

We reported last year[7] that plans appeared to be reducing marketing activities in some sites; this trend continued in 2000 and 2001. Local observers reported little marketing in Dayton and Olympia during 2000. Plans continued to market in Eugene and Springfield. In Tucson, local contacts and beneficiaries in our focus groups reported intense marketing during the fall by plan sales staff, brokers and agents targeted toward members of terminated plans. However, the plans are reported to have greatly reduced their marketing as of early 2001, and have eliminated advertising and direct mail. A few Tucson plan representatives have suggested that

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[6] The use of capacity limits adds a new information challenge for Medicare information providers. Beneficiaries need to understand how capacity limits work and how their choices are affected.

[7] *National Medicare Education Program Assessment: Medicare Managed Care Markets and Information in Six Communities 1998-2000*, Abt Associates, June, 2000.

the decision to curtail marketing and sales activities is a means to reduce administrative expenses in the face of mounting financial difficulties. One representative commented that there is little need for marketing, because with fewer plans, interested beneficiaries have such limited choices that they will contact the plans directly themselves. Some local contacts saw these decisions to eliminate sales staff as signs of the plans' lagging interest in the service areas, and think these are indications of more exits in 2001.

As part of our media monitoring[8] activity, we assessed the extent of Medicare managed care plan advertising in the major community paper in each of our sites during September 2000 – January 2001. Results are summarized in Table 2.4. We found considerable variations across and within sites:

- **We found no advertising by plans in Dayton and Olympia.**
- **In Tucson, PacifiCare Secure Horizons was advertised intensely — twice a week from October through December. During this period, we saw no ads for HealthNet. We saw no ads for either plan after December.**
- **The plans in Springfield and Eugene advertised once or twice a month during the period.**
- **Advertisements always included a schedule of informational meetings held in the area.**

Table 2.4
Medicare Managed Care Plans' use of advertising in major local newspapers September 2000 – January 2001

	Advertising	Frequency	Presence of notices about informational meetings in plan ads
Dayton	No		-
Eugene	Yes	All three plans advertised about 1 – 2 times/month	Yes
Olympia	No		-
Sarasota	N/A*		-
Springfield	Yes	Both plans advertised 1- 2 times/month	Yes
Tucson	Yes	PacifiCare advertised 2 times/week from September through December 2000, and did not advertise after 1/1/01. HealthNet did not advertise at all during the period.	Yes

Sources: **Major local newspapers in the six study sites: Dayton Daily, Register-Guard, The Olympian, Sarasota Herald-Tribune, Springfield Union, Arizona Daily Star.**
***No managed care plans are available in Sarasota as of 1/1/01.**

[8] **We reviewed the main local newspaper for each of our sites and well-known monthlies targeted to seniors in Sarasota and Tucson for the period September 2000 – January 2001 for information about topics relevant to the NMEP, including managed care issues. See our report on Information Supply for a full description of the project and our findings.**

As noted previously, more detailed information about the managed care marketplaces in the study sites is in Appendix A.

3.0 Beneficiary Attitudes Toward Managed Care and Decision-making

3.1 Beneficiary Attitudes

Local contacts report that attitudes about the attractiveness of managed care plans as a Medicare option have become more negative, and an increasing number of beneficiaries have concerns about the managed care option. Some beneficiaries, especially those affected by plan terminations or extensive benefit reductions, are described by local contacts at several sites as angry, anxious, fearful, or with a growing sense of resignation or powerlessness about being able to influence any change to improve their own or the general situation. In most of our sites, beneficiaries' attitudes are seen by local observers as the result of accumulation of three years of negative changes in the Medicare managed care markets (such as reduced benefits, increased costs, plan exits, and provider/plan conflict), which have gradually eroded beneficiaries' confidence in the managed care choice. According to some site contacts, some beneficiaries are increasingly concerned about provider networks' instability — fearing its effects on their access to health services and on the future availability of plans — as well as concerns about cost increases.

Observers in Dayton and Sarasota, where Medicare managed care is a recent development relative to other sites, noted that some beneficiaries are beginning to believe there's a pattern in plan behavior: plans enter a community, market aggressively to recruit members, then raise prices and reduce benefits, and then leave. A few observers in Sarasota commented about this issue and its effect on beneficiary attitudes, noting that beneficiaries are distrustful now — and will be so in the future — of claims about new, affordable services. They now look back and see the plans in Sarasota as offering something that was "too good to last". If another plan comes to Sarasota, observers note, some beneficiaries feel that the inevitable next steps will be increased prices and then exits.

Some local contacts note that external events can influence beneficiaries' reactions as much as personal experience. Even if an event does not happen directly to a beneficiary, but to a friend or somewhere else in the community, the occurrence makes on-lookers question whether the same thing can happen to them. For example, a contact in Olympia commented that managed care enrollees become concerned about their own access to physicians when they hear that physicians are leaving the network. Observers pointed out that since beneficiaries tend to react to plan changes by expecting that the trend will continue, a change such as an increase in premium, that may seem moderate to someone who is not on Medicare, can be perceived as far more important by a person with Medicare, who sees it as another step toward some point that represents a bad outcome for him. In Springfield, where three managed care plans have left since 1998, a managed care plan was slow to work out a contract with a local hospital. That, plus awareness of another change in the market – a large and unexplained increase in premium for another plan — worsened beneficiaries' attitudes toward managed care, according to a local observer. *"It erodes confidence"* in the plans, she commented.

Beneficiaries in Springfield and Eugene voice concerns about equity of benefits under Medicare, according to local observers. They see their own options as being less rich than those available in other locations, and wonder how, since Medicare is a national program, that can be the case. Beneficiaries in Eugene are told that their plan capitation rates are lower than other parts of the country; while those in Springfield are concerned about the higher rates paid to plans in the eastern part of the state.

Beneficiaries do not view the events happening among the managed care plans as an aspect of market forces, according to a few local observers. They tend to either blame Medicare or the plans for the instability, depending on their perception of the problem: Medicare because it is not paying enough for services, or the plans for being too profit-oriented. In either case, these are decisions in which beneficiaries have no part, thus creating their sense of helplessness or resignation.

One local contact in Tucson reported that some people were upset by the information in plan termination letters, regardless of how benevolently it may have presented. Beneficiaries were upset about the loss of their physicians, of changing physician group practices, of having to find different coverage. Some were recovering from surgery and had to transition into another hospital because their new plan network did not initially include the hospital where they had initially received care. According to this contact, any change in insurance arrangements is upsetting because seniors value stability and predictability… *"seniors don't really want choices, they want quality of care and they want to know that it is available to them."*

However, reactions from local contacts were mixed. While some feel that change itself is viewed as a negative experience, others feel that change is a fact and beneficiaries are adapting to it. A few contacts reported that some beneficiaries are demonstrating ability to adapt to the concept of annual changes in managed care benefits and costs. These professionals did not associate the concept of change with the negative trends of the past few years, and so their perspectives were less bleak. According to one, *"The general public now expects HMO plans to change every year."*

Beneficiary attitudes and behavior may have changed as a result of their perceptions of the current status of managed care. Some note that fewer beneficiaries seem to be interested in managed care. Some report increases in the number of inquiries about Medigap coverage at helplines. A few plan representatives observed that some involuntary disenrollees are turning to Original Medicare, rather than finding another managed care plan, and we found that to be the case in Dayton, Olympia, and Tucson. Several plan representatives reported that prospective members at sales meetings are now asking about the stability of the plan and its intention to stay in the service area. Beneficiaries want to know why one plan might stay, if another one had left because it claimed it could not afford to provide services. Another plan representative commented that some beneficiaries, out of fear of the instability of managed care, are not able to weigh the alternatives rationally and are making uninformed decisions to join traditional Medicare without a supplement. This behavior was also evident in some focus groups.

The lower cost of most plans still is the main attractiveness for some beneficiaries. Local contacts are aware that many who are in managed care for financial reasons have no other

option. They point to the fact that the plans still are cheaper than the cost of equivalent Medigap coverage, and until that is no longer the case, will remain an "attractive" alternative.

New Medicare enrollees choosing a Medicare managed care plan did so based on financial factors, in conjunction with previous positive experiences with managed care and personal recommendations. We conducted in-depth discussions with 31 recently eligible beneficiaries, including 14 living in the Springfield site and 17 living in Tucson, to understand what information they used, and how they used it, as they went about making initial Medicare coverage decisions. The concerns and opinions expressed by beneficiaries during those discussions provides another perspective on beneficiaries' attitudes toward managed care and how they affect decision-making. The discussion below suggests that, in these two sites at least, some of the features that attracted beneficiaries in the past, such as comparatively low cost for coverage, continue to do so today, and that many current managed care members are willing to recommend managed care to their friends and family.

The majority of the beneficiaries who agreed to take part in these discussions had enrolled in Medicare managed care plans as their initial choice of coverage. Most reported that the primary factor for deciding whether to join any managed care plan was based on financial issues, the specifics of which varied considerably among the individuals. Some reported that they simply could not afford Medigap premiums on their current incomes, including several who assumed that because they had pre-existing conditions, Medigap premiums would be unaffordable and others who reported high out-of-pocket costs for medication or other medical services for themselves or spouses. One or two beneficiaries reported dissatisfaction with their enrollment in managed care, but felt they had no alternative. Also, a few beneficiaries reported that they had decided to avoid Medigap coverage because of a perception of continuous escalation in premiums, so that although Medigap coverage might be affordable now, it was seen as an ever-increasing expense.

No beneficiaries who had selected managed care seemed to have selected a specific plan based solely on cost. Almost all managed care enrollees had either had previous positive experiences with managed care plans or obtained varying amounts of information or advice about specific plans during their decision process. Most of those who enrolled in managed care plans were satisfied with their selection, although some were more tenuous about their satisfaction, noting that if their opinions changed, they could disenroll at any time.

During these discussions, eight of the 31 beneficiaries raised concerns about the stability of managed care plans and reported that either their decisions, or their comfort with them, were influenced by these concerns. Three of these beneficiaries chose to enroll in Medigap plans because of these perceptions. (For one person, the decision was based on a very practical consideration – she had a pre-existing condition and was worried about what her Medigap premiums would cost if she had to purchase that coverage after age 65 if she enrolled in a managed care plan that later terminated.) Two who had expressed concern about stability reported that they chose managed care but had selected the plan that seemed to them least likely to terminate. For one beneficiary in Springfield, the deciding factor was the Blue Cross Blue Shield brand name of one of the managed care plans, which gave a sense of permanency. The beneficiary in Tucson tended to rely on her assessment of what she could gather about the available choices.

The attitudes of some local information providers and observers toward managed care are becoming more cautious. **We asked local contacts at our sites both about the attitudes of beneficiaries in their communities and about the messages they give about managed care. Discussions with these professionals indicate that some who had been skeptical about managed care in the past are becoming more so, and that others who may have been neutral or positive are starting to question the benefits of the program for beneficiaries. These changes in the attitudes of information providers are evidenced more in the sites with market turmoil than our quieter sites.**

For example, in Sarasota which lost both managed care plans as of 1/1/01, an information provider in Sarasota reported that he *"used to be more positive about beneficiaries having choices."* Now, he's stopped discussing it. *"I've gone from upbeat to neutral to downplaying it. I would not be encouraging now, I wouldn't want to set up people for disappointment."* According to this professional, *"The policy…hasn't turned out to be a good policy for seniors. Ten years ago, the way it was discussed, the way the HMOs articulated it–it sounded like it would be a positive experience for seniors, but it's not."* It should be remembered that Medicare managed care entered Sarasota very recently, perhaps 1997, and that very soon after entering, available plans began to exit the market in rapid succession, leaving the county "abandoned" at the end of 2000.

Local contacts in other sites that have seen less drastic changes seem to hold less negative views. However, in sites such as Tucson, Springfield, and Dayton, some information providers are becoming more wary about the managed care option. Some note that they counsel beneficiaries not to think of the plans as a long-term option, and that the *"plans might be here today, but gone the next."* Local contacts in Dayton and Tucson report cautioning beneficiaries to look more closely at the actual costs of the plans based on the individual's expectation of use of services, since benefits have changed so much during the past few years, and to compare the costs of the plans to other options. In Tucson, a local contact shares some of the views of the Sarasota contact quoted above, in that he sees the problem not so much as the behavior of the plans but more that the policy of managed care as a Medicare option is under pressure. Although he knows that the local Tucson market is very fragile and that no plans will likely remain by 2002, he believes that the current plans are making rational business decisions, even though he is also aware that these decisions will have a negative impact on beneficiaries.

3.2 Beneficiary Enrollment Decisions

This section examines beneficiary health coverage choices, and changes in those choices, in our six study sites. We analyzed data from the CMS Enrollment Data Base to identify beneficiary plan switching patterns and the differences among sites, and to determine to what extent plan choices are related to plan withdrawals and other market changes. We also examined what coverage choices new Medicare enrollees are making.

To track the actual selection behavior of beneficiaries at the six study sites, we identified aged beneficiaries who have been continuously resident at our sites since June 1998, based on CMS's

Enrollment Data Base, and tracked their enrollment in Medicare managed care plans (MMCPs) versus Original Medicare.[9]

Managed care and non-managed care enrollment were identified for each beneficiary at three-month intervals, using the first day of each quarter (January, April, July, October), starting with July 1998 up to January 1, 2001. We then added another month of observation by including February 1, 2001, in order to capture any lags in reporting to the Enrollment Data Base.[10] Data from last year's managed care report captured residency in the same way, at three month intervals from July 1998 to January 2000, and also included February 2000 in order to capture any potential "late" changes in enrollment after plan terminations at the end of the year. Altogether, 343,670 aged beneficiaries are in the "continuously resident" cohort used in this report.[11]

Table 3.1 shows the proportions of beneficiaries in Original Medicare and in Medicare managed care plans as of July 1998 and 2001.[12] The data show a slight reduction in the market share of managed care in these six sites, from 30 percent to about 27 percent.

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[9] **Beneficiaries who have moved into the sites after June 1998, moved out before January 2001, or died between these two dates were excluded. Also excluded were beneficiaries with ESRD (who are not permitted to newly join a managed care plan) and disabled beneficiaries, and those who became newly eligible for Medicare during the study period. While the non-ESRD disabled probably have very different managed care enrollment patterns and fewer Medigap options, in our site these would have been too few in any plan to permit a separate "switching analysis."**

[10] **February data were based on a March extract of the EDB, in order to minimize inaccuracies caused by reporting lags. However, it is possible that some reporting lags exceed a month.**

[11] **There are about 28,000 fewer beneficiaries who are counted as continuously resident at our sites compared to last year's report, because of deaths, moves out of the study sites, or other instances where a beneficiary was counted as not resident in the site on one of the reporting dates.**

[12] **The proportions of beneficiaries in Original Medicare and managed care are very similar to those reported in last year's report.**

Table 3.1
Enrollments in Original Medicare and Managed Care Plans in July 1998 and February 2001: All Sites

Type of Coverage	July 1998		February 2001	
	Beneficiaries Enrolled	Percent of Total	Beneficiaries Enrolled	Percent of Total
Original Medicare	240,236	69.9%	250,021	72.8%
Medicare Managed Care Plan	103,434	30.1%	93,649	27.2%
Total	343,670	100%	343,670	100%

Source: **CMS Enrollment Data Base, February 2000, February 2001.**
Base: Aged beneficiaries continuously resident in the six study sites from July 1998 to February 2001.

Table 3.2 below summarizes switching patterns as were shown in last year's report, looking at the time period of July 1998 to February 2000, and then updated to the current time, February 2001, for a total of 32 months of data. About one-third of all beneficiaries who were continuously resident in the six sites had some experience with managed care during the study period (115,304 ÷ 343,670). The table also shows that volatility in switching has continued at the sites. Now, fewer than half of the beneficiaries with any experience in managed care who were in a managed care plan at the start of our study are still in that same plan compared to 65% a year ago. The percent of beneficiaries who switched from Original Medicare to a managed care plan is almost unchanged, while those who switched from managed care to Original Medicare has more than doubled.

Table 3.2
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: All Sites

Patterns of Coverage	July, 1998 - February, 2000*		July, 1998 – February, 2001	
	No.	%	No.	%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	121,568	100.0%	115,304	100.0%
Enrolled in same MMCP throughout study period	78,849	64.9%	57,495	49.8%
Switched among MMCPs: started in a MMCP and switched to another (or more)	21,684	17.8%	25,745	22.3%
Switched between MMCP and Original Medicare, but not back again	18,426	15.1%	27,447	23.8%
Started in Original Medicare and joined a MMCP	9,553	7.8%	8,831	7.7%

Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	8,893	7.3%	18,616	16.1%
Started in a MMCP or Original Medicare, tried the other and returned to first type	2,609	2.1%	4,703	4.1%
Started in a MMCP, tried Original Medicare for a time, then went back to a MMCP	1,239	1.0%	1,578	1.4%
Started in Original Medicare, tried a MMCP (or more than one), then went back to Original Medicare	1,370	1.1%	3,125	2.7%
Total No. of beneficiaries continuously enrolled in Original Medicare	249,897	67.3%	228,366	66.4%
Total No. of Medicare Beneficiaries	371,465	100.0%	343,670	100.0%

Source: **CMS Enrollment Data Base, February 2000, March 2001.**

Base: Aged beneficiaries continuously resident in the six study sites from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP during the study period.

*** Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

The switching patterns differ among the study sites, as would be expected given the differences in managed care marketplaces. Site specific tables following the format above are in Appendix B. The table below summarizes important differences.

Table 3.3
Site Differences in Major Types of Beneficiary Switching Behavior, July 1998 – February 2001

	Total Beneficiaries with Managed Care Experience	Beneficiaries With Any MMCP Experience			
		In same MMCP throughout the study period	Started in one MMCP and switched to another (or more)	Started in Original Medicare and joined a MMCP	Started in a MMCP and switched to Original Medicare
Dayton	21.0% (20,781)	48.2% (10,022)	16.1% (3,354)	11.2% (2,333)	20.0% (4,161)
Eugene	53.5% (17,582)	79.0% (13,885)	2.2% (385)	9.5% (1,677)	7.2% (1,263)
Olympia	48.6% (8,366)	72.0% (6,023)	6.2% (515)	13.2% (1,106)	5.2% (512)
Sarasota*	14.8% (9,224)	NA	NA	NA	NA
Springfield	28.6% (14,838)	59.2% (8,780)	15.8% (2,338)	10.9% (1,621)	10.00% (1,487)
Tucson	55.5% (44,599)	41.8% (18,660)	42.0% (18,734)	4.4% (1,984)	9.4% (4,171)

Source: **CMS Enrollment Data Base, July 1998, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from June 1998 to January 2001, with any experience in managed care during the study period.
***Sarasota has no managed care plans as of 1/1/01, so these statistics would not be meaningful.**

Beneficiaries in Dayton, Springfield, and Tucson have switched more than beneficiaries in Eugene and Olympia. Not only was there more switching among plans at these sites, but also more beneficiaries who started in a managed care plan transferred to Original Medicare. In contrast, beneficiaries in Eugene and Olympia have tended to stay in the same plans they were enrolled in when the study began in 1998. And, in those sites, more beneficiaries who were in Original Medicare at the start of the study period have enrolled in a managed care plan than the opposite. The patterns in Springfield are less distinct than in the other four sites. More beneficiaries have switched plans than in Eugene and Olympia, and slightly more beneficiaries in Original Medicare have selected managed care than those in managed care plans have switched to Original Medicare.

Olympia and Eugene have been our study's most "stable" sites, in terms of the managed care marketplaces, since 1998, although as was noted in Chapter Two, that appears to be changing quickly in Olympia. Beneficiaries in the other four sites, on the other hand, have experienced plan terminations, drastic changes in benefits and costs, and provider turmoil since 1998.

Among beneficiaries in the continuously resident cohort, switching among plans or back to Original Medicare appears to be initiated more by changes in the marketplace than by beneficiaries' independent decisions. Table 3.4 below looks at the relationship between

switching and plan terminations. It identifies, among beneficiaries ever enrolled in managed care plans at the site, the amount of switching from one plan to another or to Original Medicare that is driven by plan terminations and the resulting involuntary disenrollment. Although most departing plans had minor shares of the managed care markets before the decision to terminate, beneficiaries' changes as a result of involuntary disenrollment made up the majority of the switching at most sites, from the time an announcement of plan termination was made until after the termination became effective. The single exception, which is discussed below, is during the period 4/1/99-4/1/00 in Tucson, where the departure of three plans accounted for just a quarter of all the switching that took place during the time.

To capture all the switches associated with a plan termination, we tracked enrollees, when possible, from roughly the quarter when the exiting plans tended to announce their termination plans in the media through the effective date of termination (always January 1) to the quarter after the termination. We tracked beneficiaries after official termination to ensure that most lags in reports to the EDB were included in our counts. The dates of the study period affected our ability to track the terminations of 2000 as thoroughly as in 1998 and 1999. In 1998, plan terminations were announced formally around September, although in some sites the news was available to the media earlier. We started the period of observation in July 1998, the quarter before the announcements, and followed until the second quarter, April, of 1999, to capture any changes that might have either taken place or been recorded after January 1. In 1999, the formal announcements took place in July, so we started the quarter before (April) and followed until April 2000. The third time period, 4/1/00-1/1/01, is truncated because we drew the last EDB extract in early March 2001.

Table 3.4
Beneficiary Switching and Plan Terminations in the Study Sites*

	Time Period of Observation	Percent (No.) of all MMCP Enrollees Who Switched during the Time Period	Exiting Plan(s)	Market Share Before Announce-ment	Percent (No.) of Switchers Who were Members of Exiting Plan (Involuntary Disenrollees)
Dayton, OH	7/1/99-4/1/00	22.6% (4075)	PacifiCare	15.3%	67.4% (2747)
	4/1/00-1/1/01	12.4% (2149)	Aetna US Healthcare	7.8%	63.0% (1353)
Sarasota, FL	7/1/98 –4/1/99	73.1%(5806)	Humana	77.9%	95.8% (5557)
Springfield, MA	7/1/98 – 4/1/99	16.4% (2116)	Aetna US Healthcare	9.0%	55.0% (1167)
	4/1/99 – 4/1/00	20.8% (2795)	Harvard Pilgrim Health Care	13.0%	62.3% (1741)
Tucson, AZ	4/1/99 – 4/1/00	24.6% (10,552)	BCBSAZ Humana Premier	3.9% 2.4% .02%	25.8% (2723)
	4/1/00-1/1/01	35.7% (15,141)	United Health Care Cigna	24.2% 6.8%	86.8% (13119)

Source: **CMS Enrollment Data Base, July 1998, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from June 1998 to January 2001, with any experience in managed care during the study period.

***We excluded a few small exiting plans, including Kaiser in Springfield, Cigna in Sarasota, and QualMed in Eugene, because their enrollment at the time of their exits was small to begin with and even smaller when we looked only at the beneficiaries in our cohort.**

Other changes by plans, such as benefit reductions or possibly network changes, also appear to influence switching behavior. As mentioned above, plan terminations in Tucson between 4/1/99 – 4/1/00 accounted for just 24.6% of switching, much less than in the other cases cited. We looked at this more closely, and found that another market change also significantly affected switching during the period. In mid-1999, United HealthCare announced drastically reduced benefits, especially for prescription coverage, for the 2000 calendar year. During the time period of interest, about 4700 beneficiaries switched from United HealthCare's managed care plan to other plans and Original Medicare. It appears, although we can't be sure, that these beneficiaries were switching to arrangements with more attractive benefits. Of the remaining 3,100 in Tucson who switched during the same period, about 2,500 beneficiaries transferred from PacifiCare and Intergroup, with most who left these plans going to the other plan or Original Medicare. Altogether, regarding beneficiaries in our continuously resident cohort, United HealthCare's enrollment dropped 30.2% in the period, from 13,943 in 1999 to 9,738 in 2000 (United HealthCare exited the county at the end of 2000).

Looking only at switching that is not associated with plan terminations provides a different picture of switching behavior in sites with market turmoil. We noted earlier that switching behavior is more intense in sites where plan terminations take place. To gain a view of "natural" switching behavior in those sites, we analyzed switching patterns *exclusive of* beneficiaries who experienced plan terminations. Only three sites – Dayton, Springfield, and Tucson — were appropriate for this analysis. Since all managed care plans left Sarasota, almost all Sarasota beneficiaries who were in managed care have been involuntarily disenrolled. No beneficiaries in our "continuously resident" groups in Eugene and Olympia have been affected by the small plan terminations that have taken place in those communities, so the "natural" switching behavior is as presented in Appendix B and in summary form in Table 3.3.

Table 3.5 shows switching patterns in Dayton, Springfield, and Tucson, after eliminating switching related to the involuntary disenrolled[13]. About 18% of beneficiaries with any managed care experience in Dayton and Springfield, and about 35% in Tucson, had been involuntarily disenrolled at least once during the study period. Although there are clear differences in switching patterns among the sites, likely related to the unique conditions in each community, in all three sites beneficiaries who have not been involuntarily disenrolled tend to stay in one plan even though the proportion of beneficiaries who switched among plans or returned to Original Medicare ranges widely. These differences are consistent with earlier discussions in this and Chapter 2.0 about the competitive environments at the sites. In general, however, switching patterns at these sites in this analysis now looks more similar to switching behavior in Eugene and Olympia (as seen in Table 3.3 or in the site-specific tables in Appendix B).

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[13] **Similarly formatted tables showing switching patterns of <u>all</u> beneficiaries with managed care experience at the site are in Appendix B, should the reader want to compare patterns of the two groups.**

Table 3.5
Switching Patterns of Non-disenrolled Beneficiaries who have been continuously resident July 1998-February 2001 : Dayton, Springfield, and Tucson

	Dayton		Springfield		Tucson	
Patterns of Coverage	**No.**	**%**	**No.**	**%**	**No.**	**%**
Total No. of Beneficiaries with Managed Care Experience	20,781		14,838		44,599	
Total No. of Non-disenrollees	16,921	100.0%	12,180	100.0%	28,708	100.0%
Enrolled in same MMCP throughout study period	10,020	59.2%	8,790	72.2%	18,642	64.9%
Switched among MMCPs: started in a MMCP and switched to another (or more)	1,450	8.6%	799	6.6%	6,708	23.4%
Switched between MMCP and Original Medicare, but not back again	4,995	29.5%	2,288	18.8%	2,962	10.4%
Started in Original Medicare and joined a MMCP	2,163	12.8%	1,405	11.5%	1,420	5.0%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	2,832	16.7%	1,542	5.4%	883	7.3%
Started in a MMCP or Original Medicare, tried the other and returned to first type	456	2.7%	303	2.5%	396	2.1%
Started in a MMCP, tried Original Medicare for a time, then went back to a MMCP	206	1.2%	121	1.0%	198	.69%
Started in Original Medicare, tried a MMCP (or more than one), then went back to Original Medicare	250	1.5%	182	1.5%	198	.69%

Source: **CMS Enrollment Data Base, July 1998, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from June 1998 to January 2001, with any experience in managed care during the study period.

Few Medicare beneficiaries switch to managed care once they are in Original Medicare. About half of managed care plan new membership comes from new Medicare enrollees. Table 3.6 below shows where new enrollment into managed care plans is coming from. To do this, we used a different cut of the EDB. We looked at beneficiaries who were resident at the sites on two dates, February 2000 and February 2001, as well as beneficiaries at the sites who became eligible for Medicare during that year. For beneficiaries who were Medicare eligible on both dates, we compared their coverage selections as of those dates. For those who were Medicare eligible in February 2001, but not in February 2000, we looked at coverage as of that date. For purposes of comparing the inflow and outflow of managed care membership, information on the number of enrollees who left managed care plans to enroll in Original Medicare are also included on the table[14]. This table indicates how important new Medicare enrollees are to maintaining managed care membership: close to half (48%) of all beneficiaries who joined managed care during the observation period were new Medicare enrollees. Few beneficiaries already enrolled in Original Medicare seem currently inclined to switch to managed care.

Table 3.6
Exits from and Selection of Managed Care by Current and New Beneficiaries in the Study Sites: February 2000 and February 2001

	Left Managed Care		In Managed Care			
	Switched from MMCPs to Original Medicare 2/00 – 2/01		Current Beneficiaries who switched from Original Medicare to a MMCP 2/00 – 2/01		Newly eligible beneficiaries who joined a MMCP 2/00-2/01	
	%[1]	No.	%[2]	No.	%[3]	No.
Dayton	9.9%	(2,218)	.8%	(960)	10.1%	(752)
Eugene	7.1%	(1,420)	2.4 %	(615)	29.0%	(704)
Olympia	6.9%	(708)	2.4%	(357)	32.0%	(457)
Sarasota	100%	(10,557)	N/A – Abandoned County		N/A	
Springfield	4.5%	(686)	1.6%	(866)	13.5%	(471)
Tucson	7.5%	(4,289)	3.0%	(1,864)	31.8%	(1,991)
Total who joined Original Medicare	19,878					
Total who enrolled in managed care plans	9,307		51.6%	(4,662)	48.4%	(4,375)

Source: CMS Enrollment Data Base, March 2001

Base: Aged and disabled beneficiaries resident in the study sites from February 2000 to February 2001.

[1] The percentages are based on the number of beneficiaries who were in Medicare Managed Care on February 2000.

[2] The percentages are based on the number of beneficiaries who were enrolled in Original Medicare in February 2000.

[3] The percentages are based on the number of individuals who were newly enrolled between February 2000 and February 2001.

[14] The numbers exclude beneficiaries who were resident in the site on February 2000 and enrolled in managed care plans but left Medicare or the site or died at some point during the year — this attrition averaged between 3-5% a year at the sites.

Compared to a year ago, fewer new enrollees seem to be selecting managed care. In our case study discussions, local observers have frequently commented that newly eligible aged Medicare beneficiaries (those aged 65) seem to be more comfortable with managed care than older individuals are, because many have experienced managed care while employed. This view suggests that the number of new enrollees who select managed care should be increasing. Instead, the data seen in Table 3.7 below, which shows the percent of 65 year old beneficiaries in each site who were enrolled in managed care plans as of February 2000 and February 2001, indicate that fewer newly eligible beneficiaries selected managed care in the year ending February 2001 than did new enrollees in the prior year. This table also shows that enrollment in managed care among beneficiaries over 65 at four of our sites (not in Springfield) declined from 2000 to 2001 also, but not as steeply as among the newly eligible. If new enrollees are a more sensitive barometer of attitudes about MMCPs in these sites (since other MMCP enrollees may have 'inertia' which tends to keep them from switching) then MMCP enrollment rates for those >65 may continue to fall slightly for several years.

Table 3.7
Medicare Managed Care Plan Enrollment Rates: New Enrollees and Other Aged Beneficiaries, February 2000 and February 2001

	New Enrollees*		All Other Age Groups*	
	2000	2001	2000	2001
Dayton	15.3%	12.9%	16.9%	16.1%
Eugene	39.4	34.7	47.9	46.5
Olympia	42.8	40.2	44.7	43.0
Sarasota**	10.7	N/A	11.3	N/A
Springfield	22.4	19.0	24.1	24.7
Tucson	47.1	37.0	50.2	47.5

Source: **CMS Enrollment Data Base, February 2000 and March 2001.**
Base: 2000 data: all aged beneficiaries living in the study sites in February 2000. 2001 data: all aged beneficiaries living in the study sites in February 2001.
***New enrollees are defined as those aged 65, calculated as of February 1, 2000 and 2001. All other age groups are beneficiaries aged 66 and over, calculated on the same dates.**
****Sarasota has no managed care plans as of 1/1/01.**

4.0 Supply of Information about Managed Care

This chapter focuses on the supply of information about Medicare managed care available to beneficiaries in our six communities. Local information providers play a critical role in dissemination of information about managed care, because much of what is important for beneficiaries to know about managed care choices is, in fact, local in nature. During our three years of monitoring, we observed the reactions of local information providers to significant changes in the managed care marketplaces in our sites, and watched as they have evolved, or not, in terms of skills, capacities, and interest in gathering and communicating information about Medicare managed care. We have tracked the evolution of the "partnerships" among CMS, state partners, and local information providers in each of the study communities in order to understand CMS's role in supporting local information providers and in supplying them with the information about managed care that they need. Understanding these local Medicare managed care information structures, their needs and abilities, and their potential for development, provides useful perspectives for planning future phases of the NMEP.

This chapter summarizes trends across our six study sites. Detailed site-specific descriptions of the managed care changes that took place during 2000 and the responses by information suppliers are provided in Appendix A.

4.1 Sources of Information about Managed Care

Managed care plans continue to be the main sources of information about managed care for beneficiaries. As was true in previous survey waves, results of our 2001 NMEP Community Monitoring Survey indicates that most beneficiaries (62%) who looked for information about managed care in the six communities turned to the managed care plans themselves (HMOs and insurance companies). This was true of both current managed care plan members and beneficiaries in Original Medicare.[15] The next most used sources were friends and family, medical providers, other local services organizations, and Medicare, the ordering of which changes depending on whether beneficiaries sought information via personal contact (telephone or in person) or printed materials. Survey results are discussed in Chapter 5.0. Our local contacts in the case study confirm that the plans are the main sources of information for most beneficiaries.

Managed care plans provide information to two beneficiary segments: current members and prospective members. They keep current members informed of changes in the plan and often about changes in Medicare as well, and educate them on how to use the plan, in order to maintain member satisfaction and retain membership. Although much of the formal educational communication from plans to members is through printed information, contacts in two of our sites, Eugene and Tucson, reported that at least one managed care plan in each of these sites offered fall seminars explaining benefit changes to current members. Information to

[15] **The NMEP Community Monitoring Survey asks, "In the past year, have you looked for information about HMOs or managed care? " This includes routine member questions about plan coverage, benefits and referrals as well as inquiries about the plan from beneficiaries who were members of other plans or who were in Original Medicare.**

prospective members is related to sales efforts, but plan representatives emphasize that a large portion of that is devoted to education about general Medicare as well as managed care.

In 2000, plan staff worked with SHIPs and other information providers in Eugene, Springfield, and Tucson, to inform beneficiaries of benefit and other changes. In these activities, the natural concern about the role of plan staff as "marketers" and the role of SHIPs or other community organizations as "neutral parties" seems to be recognized and settled. In Eugene, one plan representative has worked with a local service organization for several years to conduct quarterly public seminars about choices, as well as provide update seminars for plan members. In Springfield, one plan's sales staff invited a local information provider to participate in a series of 18 – 20 presentations at area senior centers, so that after she educated seniors about the changed pharmacy benefit under his plan, she could educate about options for obtaining assistance with medication needs. (This was a new development in 2000; prior to that, the plans had only teamed with information providers in seminars regarding plan terminations.) Challenged by another information provider about whether these appearances were in accordance with her agency's role as a "neutral" party (i.e., not showing favoritism toward a particular plan), she responded that her role was to help beneficiaries cope with the change, and noted that the seminars were a benefit to her own efforts at outreach. By participating in the seminars, she could reach more people with her information about services to meet prescription drug needs.

In Tucson, plan staff have participated for several years with the SHIP sponsor and a local hospital in a series of meetings, called Medicare Updates, which are designed to provide local seniors information about their choices. These appear to be set up something like an employer's health fair might be – with speakers giving information about Medicare changes, and plan staff offering personal information and printed materials to beneficiaries who approach them individually. According to local contacts, however, one of the remaining two plans did not participate in this year's (2000) sessions. As noted below, both plans have reduced marketing in the county.

The plans' role as a provider of information is declining in three sites. For beneficiaries in these communities who might be interested in exploring the option of managed care, it will be more difficult to access information from these plans. Plans in three sites, Tucson, Dayton, and Olympia are doing little marketing to prospective members, according to local contacts. Although this is not a new development for Dayton, it is new in Tucson and Olympia. In Tucson, after an intense sales effort in fall 2000 by brokers and sales agents, both remaining plans reduced marketing, and one closed enrollment in one product until fall 2001. A plan representative suggested that this is a method to reduce administrative expenses, since marketing to seniors is so expensive, but it was also interpreted by local observers to be a sign of the plan's diminished interest in remaining in the Tucson market. In Olympia, one plan markets little because it feels few new members come from that effort, and the other instituted capacity limits in early 2001 and ceased marketing altogether.

Terminating plans in Dayton, Olympia, Sarasota and Tucson provided information to disenrollees through notification letters and the use of customer service call centers to respond to inquiries. The private sector, representatives of other insurance options and private brokers targeted these groups with active sales/information campaigns. As far as we

were able to determine at our sites, no departing plan used meetings or other in-person methods to communicate transition information or remaining options to their disenrolled members in 2000. However, representatives of the remaining plans and Medigap alternatives did perceive these terminations as an opportunity and targeted those groups with seminars and personal home visits to provide information on their options. Private brokers and agents in Tucson and Sarasota undertook very active sales to attract the disenrollees to other coverage (either plans or Medigap). Participants in our Tucson focus group of disenrollees, a group comprised of NMEP Community Monitoring Survey respondents who had reported almost no information-seeking,[16] commented that the news about plan terminations had barely been announced in the newspapers before insurance agents, eager to assist them with their next choices, contacted them by mail and phone. Several members in this group reported that they did not have to make efforts to look for information, because it came to them.

Local contacts in both Sarasota and Tucson commented about problems with the responses of some private insurance agents. In Tucson, former sales staff of an exiting plan reportedly formed a private broker group, used a name similar to their former employer, and used the plan's membership lists to offer "seminars" about beneficiaries' remaining choices. They were reprimanded by the state Department of Insurance. We were also told that brokers were frightening clients by telling them that they had to enroll "right away" because network physicians' panels would soon be filled. In Sarasota, a local contact reported that some private insurance agents were trying to offer long-term care insurance as a substitute for the departing managed care plans.

Local senior service organizations indicate that the SHIPs or their sponsors continue to be the leaders in provision of public information about Medicare insurance choices, including managed care options. When we discuss "leadership" among local agencies it is important to understand that the results from our NMEP Community Monitoring Survey show that a minority of beneficiaries (currently about eight percent) who look for information about managed care report that they turn to public service organizations such as the SHIPs, advocacy groups, home health agencies, or senior centers to get it. This is far fewer than those who contact plans directly (62% of beneficiaries who sought managed care information). Information from our discussions with local contacts and beneficiaries suggests that many Medicare beneficiaries continue to be unaware of the existence of the SHIP counseling services.

Professionals who serve seniors, however, seem to be more aware of the SHIP services than beneficiaries are. However, in two study sites, local contacts are more aware of the local organization that *sponsors* the SHIP program than they are of the program itself. In Sarasota and in Tucson, local contacts identify the SHIP's sponsor as the organization that offers insurance counseling to seniors. In these cases the local sponsor has very strong name recognition in the community and provides multiple services to seniors, of which SHIP services are a small component. The SHIP programs are well-known among community professionals in Eugene, Olympia and Springfield (OSHIIP, SHIBA and SHINE, respectively). The situation in Dayton is less clearcut: some local organizations are familiar with OSHIIP, and some are more familiar with local sponsors.

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[16] **Abt Associates Inc. NMEP Community Monitoring Survey of Beneficiaries, January/February 2001**

Among local contacts at four of our sites, the SHIP or SHIP sponsor was identified by site contacts (other than our SHIP contacts) as the lead organization to handle Medicare and Medicare managed care issues. The Eugene site is one exception in that while the SHIP is most frequently named the leader for specific information about managed care (such as dealing with new Medicare enrollees or handling managed care plan withdrawals); another organization shares recognition as providing extensive Medicare information. The Dayton site is another exception where there appears to be no recognized leader for managed care information among local information providers.

In the four sites where the SHIPs or SHIP sponsors are the clear leads among local service organizations, there does not appear to be any controversy about this role. No other organizations in the communities seem to have either the resources or the mission to take on the lead responsibility for Medicare managed care information. While other community organizations do provide some information about managed care in some of our sites, this is done most often through occasional seminars and presentations that are designed to update beneficiaries about the Medicare program in general, about a specific Medicare issue, or about the coverage choices available in the site. Perhaps only one other community program among all our sites — a local hospital's senior program — purported to offer in-depth information about managed care.

4.2 Responses to Market Changes by Information Providers

Last year we reported that the shifts in the managed care environment have the potential for making new demands on local Medicare information providers because of the speed with which they happen. Other changes in Medicare, such as the expansion of preventive benefits, can be rolled out in a communications campaign that takes months; in situations like that, once decided, the basic facts don't change over time, and the main challenge is reaching the targeted audience. In contrast, managed care marketplace changes present a different challenge for information providers (local or otherwise). Such changes have taken place more frequently in the study sites, sometimes occur "off-cycle," are often specific to single geographic areas (e.g., premium increases and provider terminations) and are more dynamic, in that the facts often shift over time.

The types of market changes that took place in our sites during 2000 and early 2001 provide some sense of the challenges presented to information providers:

- **Annual announcements of changes to plan benefits and member charges (All);**
- **Follow-up changes to plan premiums made in response to BIPA (Eugene);**
- **Closed enrollment processes or institution of capacity limits which reduces access to current managed care plans. (Olympia, Tucson);**
- **Announcements of plan exits made in the newspapers and other media before the formal exit information letter in July (Sarasota);**
- **Plan terminations, requiring information about transitions, rights and responsibilities, other options available, such as Medigap, QMB, and Medicaid, and other means to fill in the gaps left in services (Sarasota, Tucson); and**

- **Network disruptions, including provider financial failures, delays in hospital contracts, provider terminations (Olympia, Springfield).**

Several tasks are associated with managing these types of information and clearly speed of transmission is frequently critical. The first task is to gather the information, which requires having reliable information sources that are willing to share their data with another organization. Information providers themselves need to understand the implications of the changes, in terms of effects on beneficiaries or specific subgroups, in order to inform beneficiaries about how their options will be affected by it. Distribution of the information has to be managed: who else needs to know, or who else needs to be trained, and what channels should be used to accomplish that. And there needs to be a capacity to permit updating, so as conditions change, new information can be transmitted efficiently.

Among our sites, the state SHIP programs are recognized as taking the central role in gathering, prioritizing, and then distributing information about marketplace changes to local SHIP programs and often to other of CMS's key partners in the state. By virtue of their administrative position, the state SHIPs have more access to information from official sources than the local SHIPs do. Most have regular contacts with other state officials, who share similar constituencies or responsibilities, and several also report that they have access to and working relationships with managed care plan executives located in the state offices of the plans.

The state SHIPs in some of our sites receive some information about managed care issues directly from CMS sources. Some of this is the result of specific efforts by CMS central and regional office staff to improve the flow of information to the SHIP programs, and frequently to other key partners as well. These initiatives, according to state SHIP contacts in our sites, have contributed to their abilities to distribute information quickly to the local SHIPs, and others, for use with beneficiaries.

Information and other supports, such as training and communications mechanisms, from the state SHIP programs are the primary means by which most local SHIPs and their sponsors keep up to date with changes to the local marketplace. The information responses made by these local programs to marketplace changes varies widely across the sites.

The discussions in the following sections describe further what we've learned about the roles and contributions of the state SHIP programs, CMS, and the local SHIP programs in the provision of managed care information at our sites. We also include some general observations about how these SHIP programs vary, and what factors seem to lead to the differences. Also included is a description of a "best practice" in terms of the partnership between the Arizona state SHIP program, CMS, and the Tucson SHIP sponsor in developing and delivering information to beneficiaries about the major managed care issues in Tucson this year.

State SHIP programs are a critical source of information about managed care market changes. **While state SHIP programs at our study sites vary widely in terms of administrative structures and operational styles, in all six sites the state SHIP programs play a vital role in providing information and support to the local SHIPs about managed care issues. As one state SHIP director described her office's role in development of information, *"The regional staff (i.e., her***

staff in the state)…get some news locally from local network affiliates in managed care networks. But for policy and rules changes, service area reductions, companies leaving Medigap market, premium changes, training and materials about existing programs or refinements to current laws, that all comes from my office, under my direction or directly from me."

State SHIP staff reach out in many directions to gather information about market changes. Clearly, CMS, through its various offices, is a major source of information for the state SHIPs. SHIP program staff also reported working relationships and information exchange with other state agencies, such as the Departments of Insurance or the state Medicaid agency, and through the key partner coalitions such as the Ohio Medicare Partners or the Arizona Beneficiary Coalition, or independently. These contacts provide important information about Medigap availability, Medicaid eligibility, and other issues that are critical to local SHIPs' abilities to provide up-to-date information to beneficiaries and to plan response strategies.

Some state SHIP personnel have developed good working relationships with administrative staff of managed care plans. This has facilitated access to important information and also provided opportunities to deliver services. In Massachusetts and Arizona, for example, state SHIP directors are able to confer directly with plans' senior staff to get information about upcoming market changes. Through those relationships, program staff have access to information before the events happen, giving them the opportunity to develop information strategies to address them. This early warning system works for both parties. According to one contact, *"The HMOs recognize the roles SHIPs play. We worked directly with the plans to plan for our presentations and how to communicate these events (i.e., terminations) to the beneficiaries."*

Another contact reported that because of early knowledge of changes by managed care plans, by the time beneficiaries were made aware of the changes, a packet of all the information necessary had been developed for distribution by local SHIP programs. The staff even had newspaper articles written, so they could be faxed out as soon as the news became public.

Our contacts reported that in 2000, some state SHIP program staff collaborated with other key CMS partners to conduct information events about market changes. In Florida, personnel from the carrier and the PRO linked up with SHINE staff to deliver a series of presentations to beneficiaries affected by managed care exits. In Massachusetts, for several years the state SHINE has hosted and produced a series of seminars, called the Health Benefits University, for professionals who work directly with beneficiaries. In 2000, the state SHINE staff used these programs as an opportunity not only to provide updated information on Medicare changes, but also to *"drill professionals on Medigap guarantee issue rights."*

State SHIP programs have established systems to distribute new information quickly to the local SHIPs. In several of our study sites, the state SHIP staff uses email and regular postal mail to distribute information that keeps local SHIP program coordinators and volunteers up-to-date. Several of our contacts commented favorably on these efforts. In Sarasota, for example, a volunteer county SHIP coordinator reported that the design of the system is workable because it does not burden her with having to pass on information to her volunteers. Instead, the state SHIP sends emails to the county coordinators on one day, thus keeping them informed, and then sends emails directly to the other volunteers the next day. Another

volunteer in Sarasota noted that the state SHIP provided carefully organized lists of non-renewing plans this summer, to keep the county-level programs informed of the changes.

State SHIP program staff work at "capacity-building" among local SHIPs, through updated training. And we know of one state SHIP director, in Washington, who has addressed the problem of matching information supply with demand. She shifts volunteers from county to county *"to meet shifting demand and need…It's a deliberate part of our strategy. And staff as well as volunteers have an investment in the program, in responding to every request within 24 hours."* She also noted that her organization has a "Crisis Plan," that her staff was able to implement when plan terminations were announced while she was out of town: *"When I returned the staff and volunteers had already done many clinics, and had scheduled 200 at hot spots in the state."*

CMS's efforts at improving communications about market changes is succeeding in some of our study sites. Our discussions about managed care changes in the study sites highlighted some special initiatives that CMS staff in the regional and central offices have undertaken since 1998. These partners reported that teleconferences, emailed updates, newsletters, and the annual Train-the-Trainer programs and accompanying materials were useful for planning responses to market changes. There were also several very positive comments about CMS staff's willingness to facilitate communications with other experts in the agency who might have special information they needed.

In general, local partners had little contact with CMS directly (although one or two participated in teleconferences or training). Their contact is primarily through the state partners. Most local SHIP programs reported getting information from state SHIP offices, as might be expected. There was one example, however, of the involvement of another state partner in our sites during 2000. In Sarasota, the local SHIP sponsor worked with the Florida PRO (Florida Medical Quality Assurance, Inc.) to conduct a nonrenewal meeting for involuntary disenrollees, in both English and Spanish.

Below is a sample of the kinds of information flows with CMS that occurred during 2000 as mentioned by our case study contacts:

- **Conference call on how plans will use BIPA funds (Eugene, local contact);**
- **Teleconference training on difference between the July and October plan termination letters (Dayton, state contact);**
- **Early information exchange to prepare for extensive plan terminations (Tucson, state contact)**
- **Access to Office of Health Plans and Provider staff to resolve individual continuity-of-care situations (Sarasota, state contact);**
- **Use of website for nonrenewal information (several sites, local contact);**
- **Receipt of copies of non-renewal letters (Eugene, state contact);**
- **Participation in Train-the-Trainer program (Tucson, Eugene, Springfield, local contact);**
- **RO participation in local congressman's Medicare forum (Eugene, state contact);**
- **Use of HMO termination information to update customer service representatives (Tucson, state contact);**

- **CMS participation by telephone in Ohio Medicare Partners meetings and in Arizona Beneficiary Coalition meetings (Dayton, Tucson, state contacts);**
- **Referrals to others in Regional Office who are experts in specific areas (Sarasota, Tucson, state contacts); and**
- **Information from CMS CO about plan terminations (several state contacts).**

The sites differed in terms of the proactiveness or reactiveness of information providers. As noted earlier, in most sites, the SHIP program or SHIP sponsor are perceived to be the leaders among community agencies in responding to market changes.[17] These organizations, sometimes working collaboratively with other agencies or the plans themselves, provided varying mixes of live events, individual counseling, and distribution of printed information to beneficiaries in 2000. When live events were offered, they were either through a regularly scheduled series of events aimed at updating beneficiaries about their coverage choices (Eugene, Tucson), or were particularly designed to assist those beneficiaries affected by market changes (Springfield, Olympia, Sarasota). Interestingly, just one or two local organizations reported using media (radio, television, newsletters, or newspapers) as a means to reach beneficiaries with information about managed care.

After tracking our sites for three years, it is apparent that one of the strongest differences across sites in terms of the local SHIPs and SHIP sponsors is whether they take a proactive or reactive approach to provision of information about managed care market changes. At several sites, the SHIPs have taken a proactive role. In 2000, the SHIP/sponsor programs in Tucson and Olympia took proactive approaches to disseminating information about the managed care changes taking place in their communities. In the Springfield site, the local SHIP program director who historically has taken a proactive approach viewed the managed care market changes as less significant than in previous years, and focused her proactive approach on educating beneficiaries about the newly expanded state prescription assistance program that is available to all Medicare beneficiaries. While the SHIP programs in Tucson and Springfield have been proactive throughout our years of site monitoring, the Olympia program has become so more recently, after the program's sponsorship was transferred to another agency and the state SHIP director began to take a personal interest in the program.

These program staff have a common concern that some beneficiaries lack knowledge about the Medicare program, and thus "don't know what they don't know" and are missing important information simply because they don't know that having it would make a difference in their situations. The focus of their proactive approach is to raise beneficiaries' awareness of issues as well as to provide timely information. One SHIP staff person noted, *"I don't think there's ever enough (there's always more people to be served). A continual focus is on outreach. You always find more areas to reach out to."* And another commented, *"You don't supply information without doing outreach. The issue isn't demand, but supply. We weren't doing a good job of outreach, people didn't know they could come to us, they didn't know they needed it! We weren't supplying much outreach, so we weren't generating demand."*

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[17] **As noted earlier, there is variation among our sites as to the recognition of the SHIP programs. In some sites, the name of the sponsor is better recognized that the separate SHIP program. In order to avoid confusion in reading this text, note that the designation "SHIP program" when discussing services also includes reference to the sponsor, unless stated otherwise.**

The difference between proactive and reactive styles shows itself in various ways among our sites, in terms of the role of the program manager, planning and preparation, the types and amount of activities undertaken, and partnerships and linkages with other organizations in the community regarding information about Medicare managed care. In the more active sites, program managers are very knowledgeable about the managed care situations in their communities, are known by name by the local plan representatives, and seem to have strong opinions about what volunteers and beneficiaries need to know. Program managers are seen as advocates for seniors as well. One plan representative in Tucson reported that the local SHIP manager contacts the plan directly when he hears from beneficiaries about plan changes that concern them. The plan representative reported that it was probably "a matter of hours" after beneficiaries had been notified about a recent unusual change before the SHIP manager was calling the plan's executive offices about the action.

The more active sites focus on outreach presentations and workshops to deliver information about choices as well as offering individual counseling, and they seem to make an effort to anticipate whether and what types of information beneficiaries need to cope with market changes. And finally, in Springfield and Tucson especially, the program managers work with other service organizations and the plans to implement information services. For example, the SHIP program manager in Tucson collaborates with a local hospital to offer Medicare Update sessions annually; this year the events attracted 3000 beneficiaries.

Although these descriptions indicate a commitment to a proactive style of delivering information about managed care, we don't mean to suggest that this is the approach taken by these organizations to <u>all</u> issues, either about Medicare or other subjects. In fact, findings about how these organizations approach issues such as addressing the needs of special populations or other Medicare topics may be quite different. It is apparent from our discussions that these organization leaders use this style when they perceive the subject to be a priority. As an example, as mentioned above, the director of the Springfield SHIP viewed the managed care changes in Springfield in 2000 as less important for seniors to be alerted about than the promotion of an enriched state-legislated program for prescription coverage for seniors.[18] So, although counseling and other services continue to be available through volunteers, she is focussing her outreach efforts on the new prescription program.

What leads to a proactive approach rather than a reactive one around provision of information about managed care? Although individual leadership styles probably play a role, we observed other factors as well in the case studies, which are discussed below.

Arrangements between the SHIP program and the sponsoring local organization seem to influence the information response to changes in the managed care marketplace. The local sponsor has a very strong influence on the shape of the SHIP program in our sites. The local SHIP program in Springfield is the most operationally independent program among our sites.

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[18] **The market changes in Springfield were not as drastic as in past years. No plans withdrew, as they had in 1998 and 1999.**

In Springfield the program is managed by a .75 FTE staff person who is responsible for its viability, and who is funded half by a local community agency and half by the state SHIP program. In the other sites, the SHIP programs are set up as components of their sponsors and depend on the sponsor for support services, such as office space and telephone access in those sites where counseling services are provided in-person, communications when the program is decentralized, and telephone messaging for sites where the volunteers deal with beneficiaries by phone from their homes. Most importantly, though, in these sites the professional staff who support the SHIP volunteers and programs on a day-to-day basis do so as only a small part of their overall responsibility, and are often funded for ten percent or less of their time. Thus, although they have some responsibility to the SHIP program, their overall priorities are determined by their employers.

One important difference among the study sites is that the leaders in Springfield, Tucson, and more recently Olympia, see Medicare issues in general as important ones in their community, while sponsors in other sites seem to see Medicare issues as less important than other issues for their community's seniors. This is no surprise in Springfield and Olympia. The Springfield SHIP program's manager is funded to focus only on the mission of that program, and so does not have to balance programmatically unrelated demands and priorities. In Olympia, the state SHIP director, also funded to focus on the SHIP mission, has taken a very active interest in strengthening the program.

The organizational arrangements in Tucson are a bit more like those in our other sites. But several factors appear to contribute to the program manager's commitment to Medicare, and especially managed care, issues. First, the SHIP manager in Tucson reported in our earlier site discussions that his agency's needs assessment showed Medicare issues at the top of the list, hence seniors in the community have provided feedback about their own perceptions of the importance of the topic. Although the Pima Council on Aging (PCOA), the SHIP sponsor, has been the lead agency for Medicare concerns from the beginning of our study, we have observed increasing responsiveness to changes in the managed care marketplace as the incidence of those changes has increased. (See below for a description of the PCOA response to changing conditions in the Tucson marketplace.) Another factor that may contribute to the agency's involvement is that fully half of Tucson's seniors are enrolled in managed care plans, so a large portion of its constituency is potentially affected. Also, the PCOA is very well-known in the city for many other programs, so it is a place where seniors might naturally turn for assistance, therefore alerting PCOA staff when there are problems. And finally, the program manager is quite knowledgeable about health care policy and delivery in general, and so appears to understand some of the more complicated issues about managed care.

Because of these circumstances, the PCOA manager is involved extensively in development of information responses to changes in the managed care system in Tucson, spending time not only on planning and development, but also extensive public speaking. Clearly much of the time he spends on Medicare issues is funded through PCOA. Therefore, CMS has a very strong partner in PCOA, because of this sharing of mutual interests and concerns. The local SHIP manager reported about Medicare information in general, *"When we first started with this, Medicare was simply part of our regular operation. It has now become a separate department, with its own volunteers. It's become a specialty area as opposed to part of everybody's role."*

In Dayton, Eugene, and Sarasota, not only are the SHIP programs dependent on very limited paid staff time at the local level, but the organizational arrangements among sponsoring agencies and the local SHIP programs seem to be somewhat vague. Lines of authority for supervision and training of SHIP volunteers appear to be fragmented. In Dayton, for example, volunteers are assigned among several different social service agencies, and although one agency seems to have the largest number of them, there doesn't appear to be communication among them. Also, it doesn't appear that any one person is responsible for the management of the SHIP function in the area. The situations are roughly similar in Eugene and Sarasota. Although this approach may be effective for dealing with some types of problems, such as the claims issues the SHIP programs initially were designed to assist beneficiaries with, it appears to be less suited to adapting to and managing the new types of information challenges currently faced in the managed care marketplace. These new challenges imply needs for a capacity to gather relatively complex information from one or more sources, interpret and distribute it, train others on the implications, respond to the implications, and update it as events unfold. SHIPs with little professional support and diffuse organizational arrangements seem less likely to have the skills and resources available to develop this capacity.

Teamwork among the CMS RO, state partners, and local organizations was a "best practice" in Tucson in 2000. Our latest discussions with case study contacts indicated that the work that was done in Arizona in 2000 to deliver timely and useful information to beneficiaries about plan terminations is an excellent example of teamwork among the three levels of partners. In this situation, the state SHIP program staff were the center of the information flows, but all the partners contributed from their own areas of expertise. This meshing of expertise made the effort successful. The professionals involved in developing this program had experienced plan terminations previously and had clearly used the lessons learned from their past experiences to improve the information system.

The state SHIP staff were able to obtain early warning information about plan terminations by gathering information directly from the managed care plans and from staff at the Department of Insurance (DoI), which is also a member of the Arizona Beneficiary Coalition. The state SHIP staff then contacted the CMS Regional Office staff to confirm and share this information, and then to develop together a strategy, in conjunction also with the DoI, to manage information in the affected areas. State contacts described the results as an "educational" approach to affected beneficiaries, rather than the "crisis" approach that had been used in 1999. One of the main messages was to urge beneficiaries not to make hasty decisions about their coverage, but instead to wait until the remaining plans' benefits were announced in October. Before they settled on this message, however, the DoI and state SHIP staff confirmed with the plans that, in fact, the networks could accommodate the growth. The DoI then issued a press release in late June telling Medicare beneficiaries throughout Arizona that they might see in the newspapers that their Medicare managed care plan was leaving the area, and urging them to learn about their options before they made any changes. The DoI distributed another press release at the end of December with information about the final guarantee issue period.

PCOA staff were trained in the Regional Office's annual train-the-trainer session in San Francisco. The presentation materials provided through the training became the basis for printed materials that were distributed to beneficiaries throughout the fall and for non-renewal and other presentations conducted by PCOA staff during these months. The staff who attended

the train-the-trainer meeting also passed on the training information to SHIP volunteers. As part of the information campaign, PCOA rescheduled its annual Medicare Updates sessions to November from April 2001, in order to include presentations about non-renewal issues and the presence of the remaining managed care plans. About 3,000 beneficiaries attended the sessions. CMS RO staff along with the Arizona Beneficiary Coalition planned and conducted a health fair in Tucson during the fall during which a nonrenewal session was held.

About 200 beneficiaries a month called PCOA for information from July through December, motivated mainly by the nonrenewals and reduction in prescription coverage. According to the local SHIP program manager, *"This is much higher than our previous level."* Because PCOA/SHIP volunteers had been cross-trained in QMB eligibility by the Arizona Medicaid ACCESS program staff, a program arranged by the state SHIP staff, all callers were screened for QMB eligibility on the initial call and also sent the information packet discussed above. During this period, the DoI posted regularly updated lists of Medigap plans and prices for all counties on its website, and also provided this information by mail.

As mentioned above, this "best practice" shows the partners working together, each contributing from their owns skills and expertise. The description shows how each partner gathered information and planned with the other parties at each level that were necessary to succeed. Had the state SHIP not had the contacts among the state agencies or the plans themselves, or had the local SHIP sponsor not had working relationships with local organizations or not seen the situation as a priority, the result would be very different.

4.3 Additional Observations About Information Provision

Having contact with local managed care plans seems to facilitate information provision. In some of our sites, local information providers have working relationships with the managed care plans. As mentioned above, in Olympia and Tucson this year, local plan representatives reported that they either informed the SHIP staff directly or were contacted by SHIP staff directly about current local events. In Olympia, a local plan took the initiative, and it prepared the SHIP program to handle inquiries from beneficiaries; it was reportedly the first time this type of contact had happened. In Tucson, the role of the Pima Council on Aging (PCOA), the SHIP sponsor, as a "watchdog" is apparently accepted and reportedly valued by the plans. Tucson plans also participate in an annual health fair type program conducted by a local hospital, PCOA, and several other service providers to give area beneficiaries updates about changes in Medicare and information about their choices. Local plans in our Springfield site describe the local SHIP staff as a neutral, but knowledgeable information source, and refer beneficiaries to the program for assistance. When one managed care plan exited in 1999, local SHIP staff participated with the plan's sales staff in a series of information forums to address transition issues and beneficiary questions.

Access to prescription coverage programs is becoming a new focus for local information providers. Local experts in all sites report that beneficiaries have become more concerned about affordable prescription coverage and calls to their programs about the topic have increased. To some extent, this new focus is a response to drastic reductions in the prescription benefits of managed care plans in several of our sites, but also, according local contacts, it appears to be a growing concern by beneficiaries in general. Note that this has placed new

demands on information providers in terms of having to develop expertise on the topic. According to a local expert in Springfield, *"Other avenues of coverage are becoming more important as supplement prices increase and drug coverage (among MMCPs) decreases."* Some site contacts believe that many beneficiaries were attracted to managed care because of the prescription coverage; as that coverage diminishes, these seniors need assistance about where to fill in the gaps. A respondent in Sarasota reported that her program serves many severely ill, low-income seniors who skip medication, or take half as much as prescribed, or in some other way risk their health because they don't have any alternative.

Local contacts in Eugene, Olympia, Springfield, and Tucson, which are all located within a driveable distance from national borders, reported that local seniors are organizing bus trips to Canada and Mexico in order to obtain lower-priced medications. A local contact in Olympia noted that the state's Insurance Commissioner had held a public meeting on prescription coverage for seniors, and had suggested that the state sponsor transportation to Canada to take advantage of lower costs. (We do not know if the suggestion has been proposed to the state's legislature.)

Information providers have begun to provide information about alternative sources for prescription coverage for seniors, such as through the Veterans Administration, pharmaceutical company programs, or state-funded programs. The Arizona SHIP program distributes a packet of information about prescription programs, prepared in advance of recent MMCP exits. The packet includes information on the Pharma (sponsored by the National Pharmacy Association) and Needymeds programs. The local SHIP program manager distributes information about eligibility for VA prescription benefits as well. Also, as noted earlier in this section, the Arizona legislature recently increased eligibility for the state Medicaid program, ACCESS, which made QMB-eligible beneficiaries eligible for Medicaid and its full prescription coverage. SHIP volunteers and staff have been trained to screen beneficiaries for eligibility to QMB and ACCESS. Although enrollment in ACCESS has the potential for disruption of health care services for beneficiaries (who might have to change physicians or health plans) the program does expand access to prescriptions for those whose income meets the federal guidelines for poverty. Other state legislation to provide prescription coverage to seniors has been proposed, but not yet passed.

The states of Florida and Massachusetts have legislated special coverage programs for eligible beneficiaries, while legislation to establish prescription assistance has been proposed in Ohio. In Massachusetts, the local SHIP staff made promotion of the program a priority this fall. The program has been expanded by the legislature (effective in early 2001), making all seniors eligible to purchase coverage, and providing full coverage if a senior's out-of-pocket prescription expenses reach $2,000 in a year. The Massachusetts SHIP program has developed worksheets for helping beneficiaries compare the costs and benefits of this state program and Medigap coverages that include prescription benefits. The Massachusetts SHIP programs also provide information about other sources of prescription assistance, such as the VA.

Information providers are increasingly called on to become more knowledgeable about other programs as they discussed managed care options. Our multi-year monitoring of the sites has witnessed a trend of some information providers to now include in their discussions more information about Medicaid, state prescription drug benefits, eligibility for VA benefits,

eligibility for QMB/SLMBY as well as more details about managed care plans such as networks, formularies, provider access, capacity limits, and the like. While there may not be a demonstrated increase in the volume of inquiries at some of our sites, the intensity of the average contact may be more demanding. Some site contacts have observed that discussions regarding managed care choices and tradeoffs are now more complex than some ever envisioned in 1998 when Medicare+Choice first began.

5.0 The Demand for Information about Managed Care

Our NMEP Community Monitoring Survey collects information on the extent to which aged and disabled beneficiaries in our six study sites look for information on managed care and the sources they use. Overall, there has been little change from last year's findings about the sources beneficiaries use to obtain information about managed care. However, there have been changes in the rates of information-seeking about managed care in some sites.

5.1 Information Seeking about Managed Care

Compared to last year, seeking information about managed care is about the same among those currently in managed care plans, and down among beneficiaries in Original Medicare.

As shown in Table 5.1, about the same number of respondents (16%) reported looking for information about managed care this year as in previous years. About 30% of those enrolled in managed care plans at the time of the survey[19] reported looking for information, similar to reports in previous years. Over the past three waves of the survey, however, the rate of looking for managed care information among beneficiaries enrolled in Original Medicare has changed. The rate at which this group of beneficiaries reported looking for information about managed care increased from 10.6% in the 1999 wave to 12% in the 2000 wave. In the 2001 wave, it decreased to 9.2%. These changes from year to year are statistically significant.

As we discussed last year, the types of questions that beneficiaries have about managed care differs depending on their coverage. Those already enrolled in managed care plans are likely to look for information about coverage within their plans as well as possibly looking for information about plan selection, if considering a change. Those enrolled in Original Medicare are more likely to have one purpose, exploring possible plan selection. Therefore, the rate of seeking information among Medicare managed care members is likely to be higher than those enrolled in Original Medicare.

Table 5.1
Beneficiaries who sought information about managed care during the previous year: 1998 – 2001*

	Baseline: September 1998	February 1999	February 2000	February 2001
Overall	20.2%	15.5%	17.7%	15.9%
Managed Care Plan Enrollees	28.2%	24.8%	28.7%	29.9%
Original Medicare Enrollees	15.6%	10.6%	12.0%	9.2%

Source: **Abt Associates, Inc. NMEP Community Monitoring Survey of Beneficiaries: September 1998, January/February 1999, January/February 2000, January/February 2001.**

[19] **Respondents are categorized by the coverage type, i.e., Original Medicare or Medicare managed care plan, they had at the time of the survey. The number of respondents in the survey who had changed from one coverage type to the other during the year was very small and does not affect interpretation of the results.**

Base: All surveyed beneficiaries.
***Each survey wave captures information-seeking for the previous year.**

The patterns of managed care information seeking reflect events at the sites. As seen in Table 5.2, beneficiaries in Sarasota and Dayton reported significantly less and in Tucson significantly more information-seeking about managed care during the year 2000 than those in the other sites. Since both managed care plans in Sarasota announced in July that they would terminate as of 1/1/01, it's logical that fewer beneficiaries overall would seek information about managed care in 2000 than in previous years. The finding for Dayton is consistent with our knowledge of conditions in the Dayton area, where two plans have exited in the past two years and enrollment in managed care has declined 10% since 1998. Also, according to local contacts, plans have reduced marketing in the area. The findings from the survey seem to suggest that Dayton beneficiaries are less interested in managed care than they were in the past.

In contrast, in Tucson, where almost half the population is in the managed care plans and where plan terminations occurred, beneficiaries reported significantly more information-seeking about managed care than in other sites. Overall, almost 30% of beneficiaries in Tucson sought information about managed care in 2000, according to our 2001survey wave. About 46% of Tucson's beneficiaries who were enrolled in managed care plans reported seeking information about managed care in our most recent wave, compared to about 14% of those enrolled in Original Medicare. These rates of information-seeking are consistent with our knowledge of conditions in that community, which has a long history of comfort with managed care plans, but lost three plans in 1999 and two in 2000. In response to that situation, Tucson beneficiaries seem to have sought information about alternatives. And according to local contacts, insurance brokers and plans marketed aggressively to recruit disenrollees into the remaining plans.

Table 5.2
Beneficiaries who sought information about managed care by study site, 1998 – 2001*

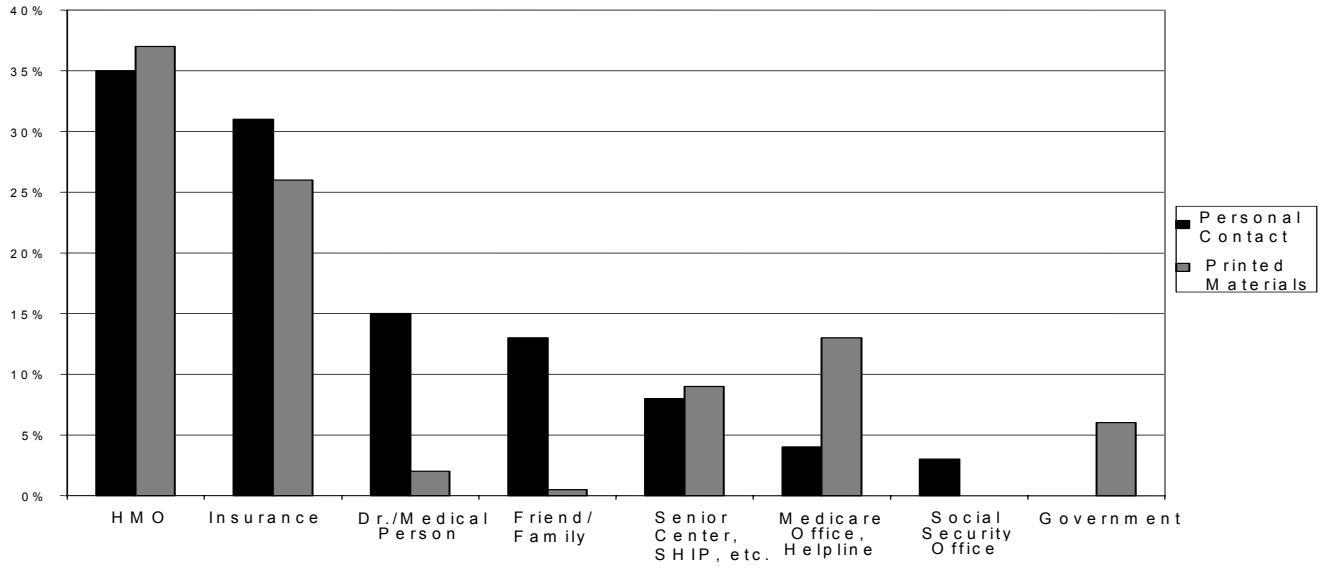
	Baseline: September 1998	February 1999	February 2000	February 2001
Dayton	19.0%	11.9%	14.5%	7.8%
Eugene	17.5%	13.1%	16.9%	14.9%
Olympia	20.1%	18.4%	17.6%	18.4%
Sarasota	23.6%	15.7%	15.4%	10.1%
Springfield	18.3%	16.5%	15.5%	15.5%
Tucson	23.0%	17.7%	26.1%	28.8%

Source: **Abt Associates, Inc. NMEP Community Monitoring Survey of Beneficiaries: September 1998, January/February 1999, January/February 2000, January/February 2001.**
Base: All surveyed beneficiaries.
*** Each survey wave captures information-seeking for the previous year**

The commercial sources of information — plans and insurance companies — continue to be those most used by respondents to find information about managed care. **As shown in Figure 1, those who seek via personal contact (in-person and by telephone) named their doctors and doctors' office staff and friends or family members next. Few respondents reported using other sources, such as senior centers, SHIP counselors, Medicare offices, or SSA offices in this way. However, senior centers, SHIP programs, and Medicare were cited more often as sources of printed information about managed care than were doctors' offices or friends. These findings are unchanged from last year.**

Figure 1: Major Sources of Information About Managed Care, 2000

Source: **Abt Associates, Inc. NMEP Community Monitoring Survey of Beneficiaries: January/February 2001.**

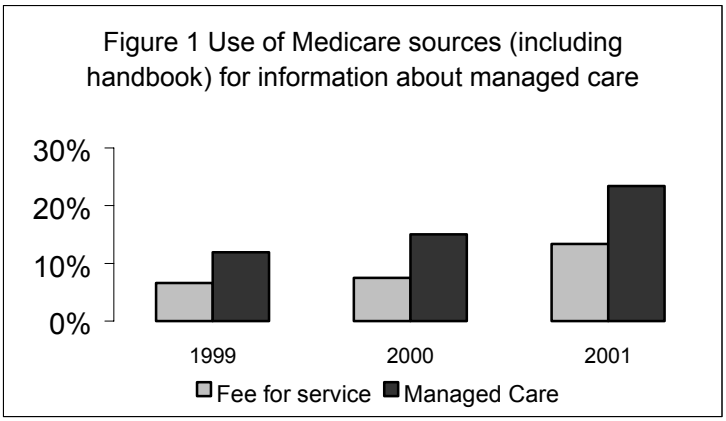


Base: All surveyed beneficiaries who reported seeking Managed Care Information.

Use of CMS information sources to find information on managed care, while low relative to commercial sources (plans and insurance companies), is increasing. **As shown in Figure 2, use of Medicare offices and helplines, the Medicare Handbook, and other printed information obtained from Medicare by beneficiaries who sought managed care information increased from 7% during 1998 to 12% during 2000, with use among those in Original Medicare accounting for most of the rise[20]. The growth was the result of increases in the use of the Handbook and other printed information; use of in-person and telephone contacts remained relatively unchanged.**

[20] **Baseline data not included because annual distribution of the *Medicare and You* handbook began after the initial survey wave.**

Figure 2: Use of Medicare Sources (including handbook) for Information about Managed Care*



Source: **Abt Associates, Inc NMEP Community Monitoring Survey of Beneficiaries: January/February 1999, January/February 2000, January/February 2001.**
Base: All surveyed beneficiaries who sought information about Managed Care.
*** Each survey wave captures information-seeking for the previous year**

There are few differences in utilization of information sources among the sites. The use of commercial entities (HMOs/Insurance companies), doctors, and senior centers/SHIPs as sources of information differed slightly among the sites, but there were no site differences in use of other sources –friends and family, Social Security offices, Medicare sources, and health fairs.

Managed Care plans and insurance companies are commonly used sources. On average across the four waves of the survey, about 69% of managed care enrollees and 53% of those enrolled in Original Medicare turned to commercial sources (that is combined survey responses of plans and insurance companies) when they sought information about managed care. While the behavior of those in Original Medicare did not differ from site to site, more managed care enrollees in Tucson (average of 78%) and fewer in Olympia and Dayton (averages of 60% and 62%) turned to commercial sources for information, compared to the other sites.

Physicians and their offices are used by a minority of beneficiaries. On average across the four waves, about 9% of beneficiaries who sought information about managed care reported asking their doctors or doctors' staff for information. Beneficiaries in Tucson reported higher than average use of this source in the first three waves of the survey, but then reported about average use in the most recent wave. However, among beneficiaries in Olympia in the most recent wave, 27% of those in Original Medicare and 17% enrolled in managed care plans reported conferring with their doctor about managed care questions. This was a very significant increase over previous years. A possible explanation is that there has been substantial turmoil among physicians in Olympia during the past year, creating needs for beneficiaries to either switch doctors or inquire whether their physician participates in a managed care plan (see Appendix A for more details of the Olympia site).

Senior Centers and SHIP programs appear to be used infrequently, except at our Springfield site. Although few beneficiaries at our sites reported using these sources, the use is significantly

higher in Springfield than in the other sites. Across all survey waves, about 15% of beneficiaries in Springfield reported using these sources when seeking information about managed care, compared to 6-9% in the other sites. We looked at responses related to the other two general "seeking" questions on the survey (for claims and Medigap) and found that looking for information about any Medicare topic in our survey at Senior Centers/SHIP programs was more common in Springfield than other sites (17% compared to a range of 9-14%). This may indicate some success by the SHIP program director in Springfield in establishing a viable information service in the area and also is consistent with our local contact perceptions that the SHIP is the main source of Medicare information at that site.

5.2 The Usefulness of Information about Managed Care

In beneficiaries' assessments of the usefulness of the managed care information they received in 2000, there were almost no differences in satisfaction across particular sources, and, with one exception, no differences among the sites. In the survey, beneficiaries used a three-point scale to rate the usefulness of the managed care information they received: very useful, somewhat useful, or not useful at all. They answered this question just once, so those who used more than one source were not asked to differentiate the usefulness of specific sources.

Across all sites, beneficiaries' assessment of usefulness of the information about managed care that they received during 2000 tended to be about evenly divided between "very useful" and "somewhat useful." However, beneficiaries in Sarasota rated the information they received far lower than residents of the other five communities. About 36% of respondents in Sarasota rated the information as "not useful," compared to 11-18% in the other sites. The satisfaction of beneficiaries in Sarasota may well have been influenced by the exit of the managed care plans in their area. Respondents tend to consider their happiness with the answers they received as part of their assessment of the usefulness of the information; and, beneficiaries in an "abandoned" community are likely to be unhappy about the situation.

People enrolled in managed care plans tended to be more satisfied with the usefulness of the managed care information they found than did those in Original Medicare (53% vs. 45% rated the answers they received as "very useful"). This may be more a reflection of the fact that beneficiaries enrolled in plans have different types of questions from those who are not, and are also more likely to know where to look to get the information they need.

5.3 Beneficiary Knowledge about Managed Care

Knowledge about Medicare managed care. As in previous years we asked a set of true/false questions about beneficiaries' knowledge of Medicare managed care. Table 5.3 below shows the overall results for the two most recent survey waves.[21] We reported last year[22] that beneficiaries enrolled in Medicare managed care plans answered correctly more often than

[21] The question about plans' freedom to change fees and benefits annually was added to the survey in 2000.

[22] *Medicare Managed Care Markets and Information in Six Communities,* op cit, p. 56.

beneficiaries enrolled in Original Medicare, regardless of any differences in education and income. The results of the most recent wave continue to show this pattern. The percentage of beneficiaries who answered correctly has not changed compared to last year, or to the two previous survey waves, on the questions about appeal rights and whether beneficiaries leave Medicare if they join a plan. While scores on the question about fees and benefits among managed care members improved from 2000 to 2001, they still indicate that 40% of managed care members are not aware of the basic tenet that plan fees and extra benefits can change from year to year.

Table 5.3
Beneficiary Knowledge about Aspects of Managed Care: Percent of Respondents who Answered Correctly

	Right to appeal HMO decisions*	Leave Medicare if join HMO*	HMOs can change fees and benefits every year*
In Original Medicare			
2000	51.5	40.8	27.6
2001	52.6	41.6	33.4
In MMCP			
2000	76.7	54.8	50.8
2001	76.4	58.7	59.0

***Source*: Abt Associates Inc. NMEP Community Monitoring Survey of Beneficiaries; January/February 2000 and January/February 2001 waves.**
Base: All surveyed beneficiaries
***Table shows percent of respondents who "correctly" answered the true/false questions and excludes those who answered incorrectly, who said they did not know the answer, or who said they were not familiar with, or not heard of, managed care plans, HMOs, or health maintenance organizations.**

This year we asked respondents about their knowledge of the terms "open enrollment" and "lock-in," two phrases that are used in the Medicare+Choice information campaign to define specific situations. We asked whether they had heard of these terms and, if they said they had, what the terms mean to them. Table 5.4 shows the percentage of beneficiaries in each coverage type who had heard of the terms and provided a definition consistent with CMS's use of them: i.e., "open enrollment" is defined as "the time when I get to make changes to my health coverage" and "lock in" is defined as "I cannot make changes to my health care."

There may be a difference in recognition of "open enrollment" by coverage type (P=.069); there is no difference related to coverage in recognition of "lock-in." Beneficiaries in Tucson and Olympia scored higher both on recognition of the term "open enrollment" and provision of a "correct" definition; there were no site differences regarding the responses to "lock-in" and its definition. In general, the results suggest that although some beneficiaries are aware of these terms, few define them in the same way as they are used in Medicare+Choice.

Table 5.4
Beneficiary Knowledge of the Terms and Definitions of "Open Enrollment" and "Lock-in": 2000

	All Beneficiaries	Enrolled in Original Medicare	Enrolled in MMCPs
Open Enrollment			
Heard of "Open Enrollment"	58.4%	57.0%	61.2%
Provided "Correct" Definition	22.0	21.4	23.0
Lock-in			
Heard of "Lock-in"	19.1	18.9	19.5
Provided "Correct" Definition	8.9	8.9	9.1

Source: **Abt Associates, Inc NMEP Community Monitoring Survey of Beneficiaries: January/February 2001.**
Base: All surveyed beneficiaries

About 58% of respondents in each coverage category reported that the recognized the term "open enrollment," and about 22% gave the "correct" answer, i.e., they understood that open enrollment refers to a limited period during which they can enroll. However, a similar percentage provided a definition that was opposite to this concept — 22% thought that open enrollment meant: "I'm free to enroll in a health plan at any time." The fact that so many beneficiaries already define the term differently from CMS suggests potential for confusion should CMS use the term without educating beneficiaries carefully as to what is meant by it.

About 20% of the respondents reported that they had heard the term "lock-in," and about nine percent provided the "correct" definition. Such low recognition of the term suggests another potential for beneficiary confusion.

6.0 Implications for Information

It is evident from our observation of our study sites that the Medicare+Choice environment and the demands for information about managed care have changed drastically from what it was, and what was anticipated future demand would be, at the beginning of the NMEP. Early in our case study, many information providers and beneficiaries at our sites had relatively simple perceptions about what was important when making a decision about whether to select a managed care plan. Their emphasis was on network adequacy (often seen as simply as "whether your doctor (or hospital) is in the plan"), the acceptability of the restraints of a PCP gatekeeper, and the financial advantages of managed care in comparison to the cost of purchasing a Medigap supplement to establish comprehensive Medicare coverage.

Although our focus groups and in-depth interviews indicate that many beneficiaries currently enrolled in plans or new to Medicare continue to see managed care as an attractive option, data from these direct contacts with beneficiaries, plan enrollment data, and reports from our case study contacts indicate that some are growing more wary of it. The changes that have taken place in the managed care environments since 1998 highlight the very fundamental differences between the options of Original Medicare and managed care that many beneficiaries were not aware of just three years ago. These were described in early sections of this report, including the potential volatility of costs and benefits and provider participation as well as availability of the option at all. A beneficiary's decision about managed care as a Medicare coverage option is more complex now than it was at the beginning of our study.

Changes in the Medicare managed care markets at our sites have created new challenges for information providers. Other changes in Medicare, such as the expansion of preventive benefits, can be rolled out in a communications campaign that takes months; in situations like that, once decided, the basic facts don't change over time, and the main challenge is reaching the targeted audience. In contrast, managed care marketplace changes present a different challenge for information providers (local or otherwise). Such changes have taken place more frequently in the study sites, sometimes occur "off-cycle," are often specific to single geographic areas (e.g., premium increases and provider terminations) and are more dynamic, in that the facts often shift over time. In recent years the CMS CO and some Regional Offices began to develop mechanisms that can quickly disseminate information about managed care plan changes to key information partners.

It's important to recognize that the demands on information providers will continue to evolve as the managed care environment changes. In 2000, for example, new information topics included capacity limits, the use of formularies in plans' prescription benefits, and alternative programs available to meet beneficiaries' prescription needs.

State SHIP programs in our sites play a vital role in managing information about managed care market changes. These organizations are well-positioned in state administrative structures to work with other state officials who share similar constituencies, as well as to coordinate with CMS and with local SHIP programs. State SHIP programs have developed the basics of reliable and consistent "information systems," using their skills and resources to collect, analyze, and distribute information about market changes and to assist local SHIPs to implement information responses to them.

Data from our case study activities this year suggest the following implications for the NMEP:

- **The changes seen in the managed care marketplaces at our sites in 1999 and 2000 appear likely to continue into next year, so communications about managed care changes will still be important**. **As noted above the CMS CO and some Regional Offices made particular efforts in 2000 to establish information flows, both structured and ad hoc, about managed care issues to state, and sometimes local, partners. These initiatives included teleconferences, blast faxes and emails, and newsletters for distribution of information to groups, as well as ad hoc phone calls and linking key partners to other CMS staff with special knowledge. These activities may become even more important in 2001, if changes in the managed care marketplaces continue.**

- **In all our study sites, the state SHIP programs have taken a leadership role in establishing "information systems" that assist local SHIPs to develop information responses to changes in local managed care markets. Since SHIP programs vary state to state, each Regional Office might consider working out an explicit arrangement with its state SHIP directors about what information is needed and what would be available from the RO.**

- **While the state SHIP directors among our study sites appear to have developed strategies to manage information about managed care issues, there's more variability among local SHIPs in terms of responsiveness and information provision. It appears, from our case study activities, that the agencies that sponsor the local SHIP programs have a strong influence on the SHIP's abilities to respond to local managed care changes. CMS might consider a special information/education initiative geared toward strengthening local sponsors' awareness and knowledge of managed care issues and their effects on beneficiaries.**

- **If new "choices" become available, the information made available to beneficiaries should address the concerns raised by some beneficiaries' experiences with managed care. Throughout this report, a common thread is the apparently increasing wariness shown by some beneficiaries about selecting managed care as a coverage option. Our local contacts report that the perceived instability of the plans and the decreasing benefits available through them make the managed care option less attractive than it once to some beneficiaries. Few who are already enrolled in Original Medicare seem to be willing to switch to managed care, and fewer new Medicare-eligibles are selecting it. Several observers in our case study reported that some beneficiaries, especially those who have been affected by market changes and plan exits, perceive now that the managed care option was "too good to be true." What ever the cause for this--whether this implies over-zealous marketing by the plans, over-enthusiasm of information providers, or wishful thinking by beneficiaries—the result seems to be cynicism and doubtfulness among some beneficiaries. This attitude, if it is held by many beneficiaries, may make it difficult for CMS to introduce new choices, should some become available.**

Appendix A

Managed Care Marketplace, Information Responses, and Attitudes of Beneficiaries toward Managed Care in the Six Study Sites

Dayton, Ohio

Market changes. In 2000, changes in the Medicare managed care marketplace in our four-county site included termination of the Aetna US Healthcare plan from Montgomery and Clark counties at the end of December and announcements by all plans of increased charges and reduced benefits for members in 2001. Similar events are happening in the rest of Ohio, according to the *Dayton Daily News* (December 8, 2000). The paper reported that Medicare managed care made a promising start in the state in the mid-90's, when enrollment in Medicare managed care among Ohio beneficiaries grew from 75,000 in 1996 to 300,000 in 1999, and the number of plans increased from four in 1994 to 14 in 1999. However, in 2000 managed care enrollment among Ohio beneficiaries declined slightly to 280,000, and four plans withdrew from the state. Since the beginning of our study, two plans have exited from Dayton, and enrollment in our Dayton site has declined 10.2%.

Aetna's departure on 1/1/01from Montgomery County, which includes the city of Dayton, followed the exit of PacifiCare as of 1/1/00, leaving Anthem (also known as Community Health Insurance) and United Health Care, the two plans with the highest enrollments, remaining in that marketplace. Information about the local provider environment from one knowledgeable local contact indicates uncertainty about the future stability of the marketplace: according to this respondent, local medical providers have begun to demand off-cycle contract renegotiations, and are requiring payment rates that exceed Original Medicare payment levels. This local contact reports that providers in the nearby cities of Cincinnati and Columbus began to renegotiate in this manner in 2000, and it's expected that the providers in Dayton will follow suit.

The benefits available in 2001 from both remaining plans are less than what was offered in 2000, increasing the amount of out-of-pocket expenses for members who need prescription medications or require hospital admission. The changes made this year follow stringent benefit reductions instituted for the 2000 benefit year. For 2001, prescription benefits were reduced in all four counties, either by raising prescription co-payments, reducing the covered amount, or by eliminating coverage of brand-name prescriptions altogether. Both plans have modified the co-payments for hospital admissions that they instituted for the 2000 benefit year. In 2001, Anthem is requiring a co-payment of $75/day during a hospital stay, while United is requiring $250/day. Both have increased co-payments for specialist outpatient visits to $20.

Information response to market changes. Our site discussions regarding the NMEP and associated information issues have focused on Montgomery County. According to local information providers, the changes in the marketplace in 2000 did not result in any unusual increase in demand for information. Although information providers noted that there were some calls and questions from affected beneficiaries, there was no public outcry. The demand for information, according to local contacts, was met through the usual channels, including telephone responses by OSHIP volunteers and helplines at two senior social service organizations. (A state-level contact reported that a non-renewal presentation had been conducted in Springfield, in Clark County, but we could not substantiate that report with others.) Several local observers contrasted the responses to the exits of PacifiCare and Aetna to the public uproar that met Anthem's announced intention to terminate its Medicare contract in 1998. They reported that the responses of beneficiaries to current Medicare events is minimal

compared to the 1998 reactions. The OSHIIP telephone statistics from Montgomery County seem to support that; according to a local contact, in the agency with the largest number of OSHIIP volunteers, the group fielded about 276 telephone calls in 2000.
Beneficiary attitudes toward managed care. One observer characterized the attitudes of Medicare beneficiaries toward managed care as "less interested" as they see plans leave, premiums increase and prescription coverage decrease. She reported that there are more calls to her organization inquiring about how to go back to Original Medicare. Another observer suggested that seniors are reluctant to get involved with plans now because benefits were cut and then plans leave and the beneficiaries are left "high and dry." At the same time, she was aware of many lower-income beneficiaries who had joined managed care plans as a means to obtain more comprehensive benefits, and as plan charges are increased, are not able to purchase Medigap plans that offer equivalent benefits.

This lack of interest in managed care was also noticed by a plan representative, who reports that sales meetings in Dayton attract only about 10 to 20 people, a much lower turnout than in other communities. He also observed that prospective members ask more questions now about why a plan is still in the area and whether it will continue. In response to this lessened interest in managed care, plus the potential for reducing the plan's administrative costs, the plan has decreased its marketing activities in the county. He also noted, however, that there's little need for marketing because with fewer plans, interested beneficiaries have such limited choices that they will contact the plan directly.

The observations of our site contacts appear to be confirmed by the enrollment data below, showing that the number of beneficiaries enrolled in managed care plans has decreased 10% since 1998.

Table A.1

Enrollment in Medicare Managed Care Plans, 1998 and 2001: Dayton

Medicare Managed Care Plan	Year			Percent Change	Percent of 2001 Market	
	1998	2000	2001	1998-2001	Total Medicare MMCP	(n=143,779)
United HealthCare	8,995	13,597	12,839	42.7%	59.5%	8.9%
Anthem (Community)	11,609	7,719	8,749	-24.6%	40.5%	6.1%
PacifiCare	3,205	–	–	–	–	–
Aetna	229	1,917	–	–	–	–
Total MMC Enrollment	24,038	23,233	21,588	-10.2%	100%	15.0%
Sterling1	–	–	92	–	–	–

Sources: HCFA Enrollment Data Base (EDB) extracts as of May 1998, February 14, 2000, and March 2, 2001.
Bases: Aged and disabled beneficiaries who were resident in the study site in May 1998, in February 2000, and in February 20001.
Enrollment includes only MMCPs available at this site. Beneficiaries enrolled in plans that are not publicly sold (e.g., those in employer-sponsored plans) are not be included in these totals. Because of this, the market share percentage is not identical to the Medicare managed care penetration rate reported in Table 2.1.
1Sterling information is provided only to show its enrollment in the site as of 3/2/01 as compared to the enrollment in MMCP and Original Medicare.

Table A.2
Medicare Managed Care – Major Benefits Changes, 2000-2001: Dayton

Plan	Premium and Visit Co-payments	Prescription Coverage	Other
Anthem Counties and products: Montgomery: 2 Miami: 1 Greene: 2	- Changed co-payments from $10/$15 to $5/$20	- Reduced brand name coverage from $500/yr to $100/qtr, kept unlimited generic coverage - Low option product offers only generic drugs	- Changed hospital stay co-payment to $75/day from $300/stay - Added product in Montgomery and Green of zero premium, generic drugs only
United HealthCare Counties and products: Montgomery: 1 Clark: 1	- Raised co-payments from $5/$20 to $20/$20 in Montgomery	- Maintained no prescription coverage in Clark County - Raised co-payment in Montgomery from $10/$45 to $12/$50. Maintain $300 cap on all prescription coverage.	- Introduced hospital co-payment of $250/day in Montgomery - Changed hospital co-payment from $700/stay to $325/day in Clark

Sources: **Medicare Compare, plan marketing materials**

Eugene, Oregon

Market changes. The managed care marketplace in Eugene has been very stable since the beginning of our study, with just one small plan, Qualmed, with 52 enrollees at the time, leaving the market during our study period. Local information providers point to a long history of managed care and a population with retiree health benefits, including managed care plans, from the local state government and university employers as possible explanations for the high penetration rate and the stability of the market. BCBS of Oregon, which offers a cost-model HMO, is the market leader, followed by Providence Health Plan. About half of Providence's membership is associated with its contract with Oregon Public Employees Retirement Services (OPERS). PacifiCare is third, with a small membership; it has a stronger presence in both Medicare and commercial managed care in the nearby cities of Portland and Salem.

Despite the stability mentioned above, managed care enrollment in the area has decreased since the beginning of our study, as can be seen in Table 1.5 below. We looked more closely at the enrollment change in 2001 and found that much of the decline is associated with Providence's decision to terminate its contract with Oregon's Medicaid agency — CMS's EDB shows about 1000 disabled and aged Medicare beneficiaries exiting Providence and returning to original Medicare 1/1/01.

In 2000, for the first time, local experts reported a disruptive change in the marketplace. One local plan, Providence, which is facing financial pressures, raised its monthly premium by $10 to $69.50, in contrast to the $4 to $6 increase implemented by the two other plans, and instituted a $300 co-payment for hospital admissions. Site contacts noted that these changes drove some Providence members to consider changing to one of the other plans. However, according to our contacts, after plan members expressed their annoyance through phone calls to the plan itself and to the state and local SHIP programs the plan announced that it would use BIPA funds to roll back the premium to $39 in early 2001 and to eliminate the admission co-payment. Providence's premium will then be the lowest in Lane County. One information provider noted that this incident indicates how competitive the Eugene market is.

Beneficiary attitudes toward managed care. Other than the one market change cited above, and the beneficiary responses to it, overall local contacts report that Eugene beneficiaries are familiar with, and comfortable with, managed care. Many "age into" the Medicare products of the managed care plans they were enrolled in as employees. Early on in our project, local observers noted that managed care had seemed to reach a saturation point, and all those who were interested had already joined, and the others were just not interested. Our data are mixed about this. Despite the stability in the marketplace and the particular attractiveness of a cost plan, enrollment in Medicare managed care is not growing. On the other hand, about 10% of our "continuously resident" group who have had managed care experience, are beneficiaries who joined a MMCP from Original Medicare. Interestingly, however, the Table B.2 in Appendix B indicates that almost all of this transfer took place before February 2000.

Eugene information providers report this year again that one major on-going concern of local beneficiaries (and, indeed, in all of Oregon) is that the Medicare managed care payment rate is lower than in other communities in the state and in many other parts of the country. Local beneficiaries see that as inequitable and depriving them of benefits available to beneficiaries in

other states, especially prescription coverage, which is not available in any plan. The representative of a large employer noted her concerns that low Medicare payment rates and rising medical costs at the plan she contracts with for retiree coverage has forced her to pass on increased medical costs to retirees.

Lane County residents continue to have easy access to information about Medicare managed care, with seminars available from several information providers. Perhaps because of the stability and history of the local marketplace, one plan plays an unusually public role in information provision. BCBSOregon (Regence) teams with Sacred Heart hospital staff and OASIS, a provider of adult education, to provide general seminars about Medicare to OASIS members and the general public twice a quarter. Attendance is in the range of 10-25 beneficiaries. Also, all three plans offer informational seminars to current and prospective members several times each month.

Table A.3

Enrollment in Medicare Managed Care Plans, 1998 and 2001: Eugene

Medicare Managed Care Plan	Year			Percent Change	Percent of 2001 Market Total Medicare	
	1998	2000	2001	1998-2001	MMCP	(n=47,959)
BCBS of Oregon	14,133	12,765	12,894	-8.8%	65.5%	26.9%
Providence Health Plan	5,785	6,635	5,405	-6.6%	27.4%	11.3%
PacifiCare	1,282	1,415	1,394	8.7%	7.1%	2.9%
Qualmed	52	--	--	--	--	--
Total MMC Enrollment	21,252	20,815	19,693	-7.3%	100.0%	41.1%
Sterling[1]	--	--	3	--	--	--

Sources: HCFA Enrollment Data Base (EDB) extracts as of May 1998, February 14, 2000, and March 2, 2001.
Bases: Aged and disabled beneficiaries who were resident in the study site in May 1998, in February 2000, and in February 20001.
Enrollment includes only MMCPs available at this site. Beneficiaries enrolled in plans that are not publicly sold (e.g., those in employer-sponsored plans) are not be included in these totals. Because of this, the market share percentage is not identical to the Medicare amnaged care penetration rate reported in Table 2.1.

[1]Sterling information is provided only to show its enrollment in the site as of 3/2/01 as compared to the enrollment in MMCP and Original Medicare.

Table A.4
Medicare Managed Care – Major Benefits Changes, 2000-2001: Eugene

Plan	Premiums and Co-payments	Prescription Coverage	Other
Blue Cross Blue Shield of Oregon Products: 2	- 10% increase in premium to $55 and $66 - Raised co-payments from $3/$3 to $10/$10	- No coverage	
Providence Health Plan Products: 1	- $10.50 increase in premium to $69.50; reduced by BIPA to $39 - Increase co-payments for specialist MD visits from $10 to $20.	- No coverage	- Introduced $300 copay for hospital stay; but rescinded as part of BIPA
PacifiCare Products: 1	- $19 increase in premium to $75.00 - Increase co-payments for outpatient visits from $10 to $20	- No coverage	

Olympia, Washington

Market changes. From the start of our case study, the managed care marketplace in Olympia has been very stable, in contrast to many other areas in Washington state that have been affected by plan terminations since 1998. Terminations continued in 2000 in other parts of Washington, affecting 32,000 beneficiaries, and several site contacts noted that nearby areas were particularly affected last year. In Olympia, just one small plan, Premera Health Plus (a BCBS plan) withdrew, affecting about 300 beneficiaries. However, in 2000 two important changes took place in the Medicare managed care market in Olympia.

One was the institution of capacity limits by PacifiCare, which has closed the plan to new enrollment since October 2000. This decision affects access to managed care for local newly eligible Medicare beneficiaries. In this site, managed care enrollment has been split between two well-established companies: Group Health of Puget Sound and its subsidy, Options Health Care, and PacifiCare. The two companies offer different health delivery models — Group Health is a staff model plan and PacifiCare a community model. According to knowledgeable contacts, newly eligible Medicare beneficiaries who have not been Group Health members before retirement tend to join PacifiCare, while new membership in Group Health primarily comes from beneficiaries who "age into" Group Health's Medicare product from its commercial products. Table A.5 below shows that Group Health's enrollment has been almost flat since 1998 and local contacts report also that Group Health does little marketing in the county.

The other marketplace change in 2000 was the financial failure of one of the two major physician groups with which PacifiCare contracted, which was a factor in the decision to institute the capacity limits mentioned above. According to local contacts, it's possible that the clinic where many of these physicians are actually based may also fail. Although PacifiCare has been able to reestablish contracts with the majority of these physicians on an individual basis, these events hallmark the growing uncertainty in the environment. In addition, there is a new shortage of primary care physicians in the area, and in 2000, one local observer noted that some physicians refused to deal with Medicare HMOs. As a response to the problems of maintaining an adequate network, PacifiCare instituted a capacity waiver regarding membership in Thurston County, as well as other counties in the state, effectively closing the plan to new enrollment in October, when disenrolled Health Plus members were looking for an alternative. PacifiCare is using BIPA funds for provider support.

The turmoil in the medical market affected the general public as well as Medicare beneficiaries. The local newspaper, *The Olympian*, reported that "…dozens of Thurston County physicians are leaving the area, retiring early, or closing their practices to new patients because of low state, federal and insurance reimbursements for services and because of escalating administrative costs." The article also noted, "A growing number of family practitioners and internal medicine physicians also report they have stopped taking any kind of managed-care, or HMO, insurance, and at least one Olympia physician has opened a cash-only practice." And, the article cited the financial failure of four insurance companies and provider networks in recent months, including "…Memorial Clinic Health Network (not the clinic itself), with 23,000 patients and more than 400 physicians in several counties, including Mason and Thurston, folded in 2000. Officials said low payments from PacifiCare could not sustain the network,

while PacifiCare officials said the network had made some bad business decisions…Memorial Clinic officials in April announced that the 51-year-old clinic, with 74 doctors and thousands of patients, would dissolve its medical services on July 1. Clinic physicians are deciding individually whether to set up practices in the area or to leave. The clinic already had lost more than 20 physicians since January 2000." (May 13, 2001; Home Page Stories at internet site)

Regarding plan benefits for 2001, both PacifiCare and Group Health increased monthly premiums, and PacifiCare also raised co-payments for physician services. The GHP monthly premium was raised from $29 to $54 initially, and will be reduced, via BIBA funds, to $41.

Information response to market changes. The local SHIP program, SHIBA, reported that it offered 20 workshops in the county to assist beneficiaries with their concerns about plan exits, the institution of capacity limits, and provider disruption. The program director noted that this proactive approach is a sign that the SHIBA program has been strengthened since the start of our study, when it was one of the weaker SHIBA programs in the state. Another information provider, who characterized his organization's approach as "demand – response," reported an increase in requests for information about Medigap options.

Beneficiary attitudes toward managed care. Local contacts reported that beneficiaries are frustrated by the instability of the managed care option available through Medicare. A few noted that the instability throughout the state, which has been covered in the media, could influence the attitudes of beneficiaries living in Olympia. One knowledgeable contact reported data that indicates an increase in the number of beneficiaries who are selecting original Medicare without supplemental coverage, viewing it as a sign of the doubts that these individuals have about managed care.

Table A.5

Enrollment in Medicare Managed Care Plans, 1998 and 2001: Olympia

Medicare Managed Care Plan	Year			Percent Change	Percent of 2001 Market Total Medicare	
	1998	2000	2001	1998-2001	MMCP	(n=26,855)
PacifiCare	3,987	5,276	5,080	27.4%	49.2%	18.9%
Group Health	4,188	4,120	4,308	2.9%	41.7%	16.0%
Medicare Demo1	294	477	593	101.7%	5.7%	2.2%
Options Health Care	414	368	347	-16.2%	3.4%	1.3%
Premera HealthPlus	327	343	--	--	--	--
Total MMC Enrollment	9,210	10,584	10,328	12.1%	100.0%	38.5%
Sterling2	--	--	7	--	--	--

Sources: HCFA Enrollment Data Base (EDB) extracts as of May 1998, February 14, 2000, and March 2, 2001.
Bases: Aged and disabled beneficiaries who were resident in the study site in May 1998, in February 2000, and in February 20001.
Enrollment includes only MMCPs available at this site. Beneficiaries enrolled in plans that are not publicly sold (e.g., those in employer-sponsored plans) are not be included in these totals. Because of this, the market share percentage is not identical to the Medicare managed care penetration rate reported in Table 2.1
1For Military retirees only.
2Sterling information is provided only to show its enrollment in the site as of 3/2/01 as compared to the enrollment in MMCP and Original Medicare.

Table A.6
Medicare Managed Care – Major Benefits Changes, 2000-2001: Olympia

Plan	Premium and Visit Co-payments	Prescription Coverage	Other
Group Health of Puget Sound Products: 1	- Premium increased from $29 to $41/mo.	- No coverage - Discount program available through staff model pharmacies	
Options Health Care Products: 1	- Introduced premium of $41/mo	- No coverage	
PacifiCare Products: 1	- Premium increased from $20 to $55/mo. - Outpatient visits co-payment raised to $10 from $5.	- No coverage	- Capacity Limits instituted 10/00. No new enrollment

Sarasota, Florida

Market changes. Medicare managed care was new to Sarasota County in 1998 when our case study began; three of the four plans available in 1999 had entered within a year. From the beginning of the case study, there was disruption in the managed care marketplace: in December 1998, Humana Health Plan, at the time the market leader, exited the county, followed by Cigna, which had a very small membership at the time, in December 1999. The two remaining plans, United Health Care and U S Healthcare, terminated services as of January 1, 2001, affecting 10,000 beneficiaries. According to local contacts, plans had difficulty establishing and maintaining adequate provider networks, which affected costs and hindered their ability to attract membership.

Information response to market changes. Local observers reported that there was little public outcry associated with the two plans' decisions to terminate. Both plans provided the official notification letters and responded to inquiries to their customer call centers. One plan representative reported that there was no increase in calls from Sarasota residents, as far as she could tell.

The local SHIP was able to absorb an increased demand for 1-1 counseling, which totaled about 600 clients from July through December 2000. Additionally, the SHIP program and its sponsor in Sarasota hosted two presentations for disenrollees, one in English and one in Spanish. Attendance at the workshops totaled about 55 beneficiaries. The sponsor also distributed printed materials about beneficiaries' option to disenrollees who called the local Elder Helpline, estimated to be 300/month from October through December. The Atlanta CMS RO staff conducted a non-renewal meeting, which was scheduled somewhat hurriedly, and attracted five beneficiaries. As far as we could ascertain, there were no other specific information efforts by Medicare information providers.

Case study contacts, and our review of the local newspaper, indicated that insurance agents and brokers assertively marketed Medigap options to the disenrolled members.

Beneficiary attitudes toward managed care. As might be expected, local contacts reported that beneficiaries, when they expressed themselves to local officials, were angry and disappointed about the loss of managed care coverage. A few local observers noted that managed care plans had entered the county with such promise, had marketed aggressively, and then raised benefits, and then just left, emphasizing that these arrangements could not be trusted.

Table A.7

Enrollment in Medicare Managed Care Plans, 1998 and 2001: Sarasota

Medicare Managed Care Plan	Year			Percent Change	Percent of 2001 Market	
	1998	2000	2001	1998-2001	Total Medicare MMCP	(n=96,324)
United HealthCare	1,908	7,579	--	--	--	--
Humana	8,575	--	--	--	--	--
Aetna US Healthcare	548	2,505	--	--	--	--
Cigna	3	--	--	--	--	--
Total MMC Enrollment	11,034	10,084	--	--	--	--

Sources: HCFA Enrollment Data Base (EDB) extracts as of May 1998, February 14, 2000, and March 2, 2001.

Bases: Aged and disabled beneficiaries who were resident in the study site in May 1998, in February 2000, and in February 20001.

Enrollment includes only MMCPs available at this site. Beneficiaries enrolled in plans that are not publicly sold (e.g., those in employer-sponsored plans) are not be included in these totals. Because of this, the market share percentage is not identical to the Medicare managed care penetration rate reported in Table 2.1.

Springfield, Massachusetts

Market changes. Our local experts reported that 2000 was a quiet year in the managed care market in Springfield, compared to the plan terminations and the drastic change in pharmacy coverage available through plans that took place in 1998 and 1999. As can be seen in Table A.11 below, the market has consolidated during the past three years, leaving the two managed care plans that were largest in 1998 to serve the county. Although a third plan, Fallon Health Plan, has a presence in the county, its service area is currently limited to several towns. Prescription coverage was the major concern in 2000, according to local contacts. It had emerged as a major concern in 1998, when a state law requiring Medicare HMOs to provide unlimited coverage was overturned in favor of Medicare's less generous requirements, and the state legislature took action to develop financial assistance for beneficiaries.

Blue Care 65, a product of Blue Cross of Massachusetts, appears to have a competitive edge in the county and by February 2001 captured almost 60% of the market. BC65's contract with the leading local tertiary hospital, Baystate Medical Center, seems to be an attraction, while Tufts Health Plan, according to local observers, took a long time to establish a contract with another local hospital, Mercy.

Both plans announced reductions in benefits and increased charges for members for 2001. The change most noted by local experts was BC65's action to increase its premium from $25 to $105 per month, while Tufts increased its premium by $10 to $45. Premiums were introduced in the 2000 benefit year, so it was a shock to some beneficiaries that the cost would escalate to much in a single year. Plans also changed their pharmacy coverage for the third year: both raised co-payments for generic and brand name prescriptions, and Tufts raised its co-payment for brand name medications not on its formulary to $35. BIPA funds are being used by Tufts to improve provider payments and by BCBSMA to roll back the premium to $95/month.

Both remaining managed care plans have continued marketing, using informational seminars and presentations at senior centers and to other organizations in the county.

Information response to market changes. According to our site observers, there were no special efforts by local senior service organizations to be proactive about the benefit changes of the managed care plans announced for 2001. Local information providers relied primarily on helplines and individual counseling to assist beneficiaries with their specific concerns. The market changes may also have been covered in more general training sessions, presentations, and newsletters organized by the local SHIP (SHINE) in the county. In general, during this year, local information providers focused more intently on distributing information about prescription coverage, which, as noted above, is seen as one of the primary unmet needs of the state's beneficiaries now that Medicare managed care plans are no longer required to provide unlimited coverage.

One plan in the area seems to be making special efforts at providing information to beneficiaries. Local contacts reported that, in the spring of 2000, staff of the plan initiated a series of 18-20 presentations to beneficiaries at local senior centers, aimed at explaining its cutbacks and reductions in benefits to local seniors. Plan staff teamed with a senior center

educator to teach consumers how to "cope with the loss" of prescription benefits, and what alternatives are available for obtaining prescription coverage.
Beneficiary attitudes toward managed care. Two local contacts described the beneficiaries they see as angry about the increase in the Blue Care 65 premium. Another contact noted that beneficiaries were especially angry that premiums went up in western Massachusetts but not in the eastern part of the state. This comment echoes concerns expressed in previous years about the disparity in capitation rates between the more urban east and more rural west, which resulted in poor benefit packages for beneficiaries living in the west. Another pointed out that some seniors among her clients are worried that they will not be able to continue to afford managed care coverage. They are concerned that the trend of raising prices and decreasing benefits will continue, "Most folks are scrambling to keep enrolled and trying to find out how they can come up with an extra $100 a month."

Another commented that general attitudes toward managed care have gotten worse. Beneficiaries' confidence in managed care plans has been eroded, not only because of Blue Care 65's premium increase, which was not explained well to local members, but also because of the uncertainty brought about by the length of time it took for Mercy Hospital and Tufts to reach a contract. During that period of negotiation, local Tufts members were uncertain as to whether Tufts would have a contractual relationship with any hospital in the county. However, a Tufts representative took a different view, suggesting that this possibility was never really an issue. Another observer commented that beneficiaries have become resigned to managed care changes, "People are numb to the changes at this point. At least (the premiums) are better than Medex."

Several observers reported that beneficiaries' attitudes have been affected not only by the circumstances related to managed care, but also by increasing costs for Medigap and prescription costs. (Note that a state-level expert reported that Medigap rates were increased 9.9%, the maximum allowed by state law, by both Blue Cross and AARP, the two major carriers, for the 2000-20001 benefit year.) One person commented that beneficiaries are feeling increased anxiety and frustration about the complexity of the health care system overall. Several information providers reported that the most important topic for beneficiaries overall is prescription coverage. In response, these contacts noted that their main goal for 2001 is ensuring that adequate information about options for obtaining prescriptions is available, such as the state's new changes to its prescription coverage program or access to other sources such as the VA.

Table A.8

Enrollment in Medicare Managed Care Plans, 1998 and 2001: Springfield

Medicare Managed Care Plan	Year			Percent Change	Percent of 2001 Market	
	1998	2000	2001	1998-2001	Total Medicare MMCP	(n=74,302)
HMO Blue	6,387	8,530	8,885	39.1%	56.3%	12.0%
Tufts	6,355	7,105	6,753	6.3%	42.8%	9.1%
Fallon	82	132	148	80.5%	0.9%	0.2%
Harvard Pilgrim	1,574	--	--	--	--	--
Aetna US Healthcare	1,404	--	--	--	--	--
Kaiser	165	--	--	--	--	--
Total MMC Enrollment	15,967	15,767	15,786	-1.1%	100.0%	21.2%

Sources: HCFA Enrollment Data Base (EDB) extracts as of May 1998, February 14, 2000, and March 2, 2001.
Bases: Aged and disabled beneficiaries who were resident in the study site in May 1998, in February 2000, and in February 20001. Enrollment includes only MMCPs available at this site. Beneficiaries enrolled in plans that are not publicly sold (e.g., those in employer-sponsored plans) are not be included in these totals. Because of this, the market share percentage is not identical to the Medicare managed care penetration rate reported in Table 2.1.

Table A.9
Medicare Managed Care – Major Benefits Changes, 2000-2001: Springfield

Plan	Premium and Visit Co-payments	Prescription Coverage	Other
Blue Cross Blue Shield of Mass. Products: 1	- Increased premium from $25 to $105/month. BIPA reduction to $95/month. - Physician copays changed to $5 PCP, $15 SCP	- Coverage from $125/qtr to $150/qtr - Co-payment raised to $8/$15 from no co-payment	- No other significant change
Tufts Health Plan Products: 1	- Increased premium from $35 to $45/month.	- Raised co-payment for non-formulary prescriptions to $35 - Generic drug co-payment reduced to $5	- No other significant change
Fallon Health Plan (covers small portion of county) Products: 3	- Introduced premium of $30/mo.	- No change	- No other significant change

Tucson, Arizona

Market changes. The Tucson managed care marketplace continued to be volatile in 2000, after losing three out of seven plans as of 1/1/00. Two managed care plans exited the county as of 1/1/01 – Cigna, the smallest plan in the market, with about 4500 members, and Health Partners, owned by United Healthcare. Health Partners had been the second largest plan at the beginning of our study, but had dropped to third place by 2000, with 15,000 enrollees.

The remaining two plans, PacifiCare and Intergroup, instituted significant, and complicated, benefit reductions for 2001, following similar decisions in 2000. As can be seen in the table below, both increased charges to enrollees and continued to ratchet down prescription coverage in particular. Both plans increased co-payments for hospital admissions; and PacifiCare introduced a tiered approach to admission co-payments, so that beneficiaries' payments vary according to the institution in which they receive services. Although both have maintained zero-premium Medicare products, neither offers brand-name prescription coverage in those programs. Only PacifiCare provides brand-name coverage now, through a product that requires a $25 monthly premium. PacifiCare also eliminated one product for 2001; it now offers three to local beneficiaries, two of which provide only coverage for generic prescription drugs.

Tension between the managed care plans and the provider community is escalating, according to local experts, and some hospitals are refusing managed care contracts. This activity started in 1999 when University Medical Center terminated all its contracts with local plans. In 2000, other hospitals began to threaten to follow suit. One state contact reported that the number of provider groups willing to contract with plans has been cut by half, and that the biggest problem for beneficiaries is access to primary care physicians. Local contacts also reported that area physicians are beginning to refuse managed care contracts. However, local plan representatives did not describe the situation as bleak, and reported attempting to contract with physicians who had participated with departing plans.

Meanwhile, at least one of the remaining plans is challenged with financial instability. Intergroup, which started as a local managed care plan, was recently merged with HealthNet (formerly Foundation Health Services). Articles in the local newspapers cite operating losses of $26million in the first nine months of 2000 (*Arizona Daily Star,* November 11, 2000, p. A1.)

Private brokers and agents, who are empowered to sell both plans as well as Medigap coverage, aggressively marketed to disenrollees from the time plan terminations were announced in July throughout the Fall. Several site contacts reported that released United Health Care sales staff organized themselves as brokers and used the plan's membership lists for their own marketing purposes, to the point that they were reprimanded by the Department of Insurance. Despite these active sales efforts, 20% of the disenrollees from Cigna and Health Partners returned to Original Medicare rather than selecting a remaining managed care plan. Medigap costs are also increasing: one local observer reported that Plan C Medigap plans cost from $110-125/month, while Plan J can cost as much as $330/month. Local contacts reported that some beneficiaries are staying with managed care only because they can't afford Medigap coverage.

Local contacts reported that PacifiCare closed its enrollment process in early 2001 for its premium product, and is seeking to institute a capacity limit waiver, and Intergroup has limited its marketing activities. One or two observers commented that the future looks bleak for Medicare managed care in Tucson. One local expert noted that beneficiaries don't recognize that these decisions to cease marketing are important signs of lagging interest by the two remaining plans; he expects that one or both of the remaining plans will exit the county in 2001.

Information reponses to local changes. The disenrollment of about 20,000 beneficiaries and changes to the 2001 benefits in the remaining plans was the major concern of local information providers. Local and state information providers reported that they were more prepared to managed beneficiaries' needs for assistance this year than they were last year. One SHIP contact reported that the organization was able to beginning planning its response before July because of its ability to exchange information with CMS and the local plans. Because they were able to get an early start, one contact noted that they were able to take a more educational approach this year, an improvement over their crisis reaction of last year. The leader for Medicare information in Tucson, Pima Council on Aging (PCOA), the SHIP sponsor, also worked with Tucson Medical Center, to reschedule their annual meetings, called Medicare Updates, for area seniors from March 2001 to November 2000. These meetings, which have been held for 13 years, attracted 3000 beneficiaries this year, according to one of the sponsors.

PCOA also put together letters and information packages that were sent to beneficiaries who called the council about the nonrenewals. PCOA representatives reported that during the Fall about 200 beneficiaries a month called about this topic and that in addition to sending information out, callers were screened for eligibility for QMB. (The Arizona legislature recently raised the state's ceiling for eligibility for Medicaid, according to local observers, so more low-income beneficiaries have access to prescription coverage.)

Neither departing plan offered information beyond the formal notification letters and call center responses to members. However, when benefit changes were announced in September, PacifiCare held a series of meetings with current members, in conjunction with Tucson Medical Center, to explain why the plan's benefits were reduced for 2001, according to two site contacts. One contact noted that the PacifiCare speaker took pains to make it clear to his audience that the prescription coverage and other benefits being discussed were commitments for this year only, and that changes were possible in the following year.

Beneficiary attitudes toward managed care. One contact noted that some beneficiaries are scared and confused, some are angry, and (others) are cynical, feeling that "it's getting worse and there is nothing that can be done." One observer commented that when plans reduce their benefits, beneficiaries view it as Medicare taking benefits away from them, and they blame the Government more than they blame the plans. He noted that beneficiaries are becoming more and more aware of the lack of security of the managed care plans, but they want them because it is a way to get access to prescription coverage. Yet, these observers commented that, if beneficiaries think about it, they will realize that the financial coverage of generic prescriptions by the remaining plans is minimal, because of required co-payments, and that beneficiaries could do almost as well to fill their prescriptions directly.

Another observer reported that the trade-off between the enhanced benefits of a managed care plan versus the freedom of physician access in original Medicare is becoming less clear. He

noted that when plans take away drug benefits, people say "why am I on this plan anyway?" However, he pointed out that the least expensive Medigap plan was about $125 a month, and some could not afford that alternative. On another topic, a few contacts observed, too, that Tucson beneficiaries have learned from the experiences of last year; they were more likely to wait to change plans until the remaining plans' new benefits are made public in September.

Enrollment in Medicare Managed Care Plans, 1998 and 2001: Tucson

Medicare Managed Care Plan	Year			Percent Change	Percent of 2001 Market	
	1998	2000	2001	1998-2001	Total Medicare MMCP	(n=124,928)
PacifiCare	20,592	23,347	33,140	60.9%	59.4%	26.5%
Intergroup	12,424	16,235	22,663	82.4%	40.6%	18.1%
CIGNA	3,086	4,466	--	--	--	--
Humana	1,590	--	--	--	--	--
Health Partners (United)	18,228	15,071	--	--	--	--
Blue Cross Blue Shield	1,876	--	--	--	--	--
Premier Health Care of Arizona	28	--	--	--	--	--
Total MMC Enrollment	57,824	59,119	55,803	-(3.5%)	100.0%	44.7%
Sterling1	--	--	22	--	--	--

Sources: HCFA Enrollment Data Base (EDB) extracts as of May 1998, February 14, 2000, and March 2, 2001.
Bases: Aged and disabled beneficiaries who were resident in the study site in May 1998, in February 2000, and in February 20001. Enrollment includes only MMCPs available at this site. Beneficiaries enrolled in plans that are not publicly sold (e.g., those in employer-sponsored plans) are not be included in these totals. Because of this, the market share percentage is not identical to the Medicare managed care penetration rate reported in Table 2.1
1Sterling information is provided only to show its enrollment in the site as of 3/2/01 as compared to the enrollment in MMCP and Original Medicare.

Table A.11
Medicare Managed Care – Major Benefits Changes, 2000-2001: Tucson

Plan	Premium and Visit Co-payments	Prescription Coverage	Other
PacificCare Products: 3	- Increased premium to $25 in high option product - Raised co-payments to 15/15	- Eliminated brand-name coverage in zero premium products. Generic prescription coverage only. - "Plus" product - $1000 brand name coverage, plus unlimited generic. Reduced from $2500 in 2000 high-option product - Raised co-payments from $7/$15 to $10/$25 in high option	- Introduced $350 /hospital stay co-payment in zero premium product - Tiered hospital co-payment for premium product– $0 in network hospital, $150/stay in non-network hospital
Intergroup (FHS, HealthNet) Products: 1	- Raised co-payments to $15/20	- Eliminated brand-name coverage (from $1500 in 2000) - Generic coverage only	- Introduced $500 /hospital stay co-payment - Eliminated 1 product

Appendix B

Enrollment Dynamics: Changing Patterns of Coverage in the Six Study Sites

Table B.1
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: Dayton

Patterns of Coverage	July, 1998 - February, 2000* No.	%	July, 1998 - February, 2001 No.	%
Enrolled in same MMCP throughout study period	11,375	52.5%	10,022	48.2%
Switched among MMCPs: started in a MMCP and switched to another (or more)	4,225	19.5%	3,354	16.1%
Switched between MMCP and Original Medicare, but not back again	5,513	25.4%	6,494	31.2%
Started in Original Medicare and joined a MMCP	2,363	10.9%	2,333	11.2%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	3,150	14.5%	4,161	20.0%
Started in a MMCP or Original Medicare, tried the other and returned to first type	570	2.6%	911	4.4%
Started in a MMCP, tried Original Medicare for a time, then back to a MMCP	335	1.5%	459	2.2%
Started in Original Medicare, tried a MMCP (or more than one), went back to Original Medicare	235	1.1%	452	2.2%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	21,683	100.0%	20,781	100.0%
Total No. of Medicare Beneficiaries	106,240		98,858	

Source: **CMS Enrollment Data Base, February 2000, March 2001.**

Base: Aged beneficiaries continuously resident in the study site from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP at any time during the study period.

*** Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

Table B.2
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: Eugene

Patterns of Coverage	July, 1998 - February, 2000* No.	%	July, 1998 - February, 2001 No.	%
Enrolled in same MMCP throughout study period	15,597	83.7%	13,885	79.0%
Switched among MMCPs: started in a MMCP and switched to another (or more)	275	1.5%	385	2.2%
Switched between MMCP and Original Medicare, but not back again	2,516	13.5%	2,940	16.7%
Started in Original Medicare and joined a MMCP	1,606	8.6%	1,677	9.5%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	910	4.9%	1,263	7.2%
Started in a MMCP or Original Medicare, tried the other and returned to first type	238	1.3%	372	2.1%
Started in a MMCP, tried Original Medicare for a time, then back to a MMCP	101	0.5%	124	0.7%
Started in Original Medicare, tried a MMCP (or more than one), went back to Original Medicare	137	0.7%	248	1.4%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	18,626	100.0%	17,582	100.0%
Total No. of Medicare Beneficiaries	35,520		32,859	

Source: **CMS Enrollment Data Base, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP at any time during the study period.
*** Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

Table B.3
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: Olympia

Patterns of Coverage	July, 1998 - February, 2000* No.	%	July, 1998 - February, 2001 No.	%
Enrolled in same MMCP throughout study period	6,937	79.1%	6,023	72.0%
Switched among MMCPs: started in a MMCP and switched to another (or more)	441	5.0%	515	6.2%
Switched between MMCP and Original Medicare, but not back again	1,304	14.9%	1,618	19.3%
Started in Original Medicare and joined a MMCP	1,135	12.9%	1,106	13.2%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	169	1.9%	512	5.2%
Started in a MMCP or Original Medicare, tried the other and returned to first type	93	1.1%	210	2.5%
Started in a MMCP, tried Original Medicare for a time, then back to a MMCP	51	0.6%	68	0.8%
Started in Original Medicare, tried a MMCP (or more than one), went back to Original Medicare	42	0.5%	142	1.7%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	8,775	100.0%	8,366	100.0%
Total No. of Medicare Beneficiaries	18,610		17,214	

Source: **CMS Enrollment Data Base, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP at any time during the study period.
*** Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

Table B.4
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: Sarasota*

Patterns of Coverage	July, 1998 - February, 2000** No.	%	July, 1998 - February, 2001 No.	%
Enrolled in same MMCP throughout study period	1,437	14.5%	115	1.2%
Switched among MMCPs: started in a MMCP and switched to another (or more)	4,724	47.7%	419	4.5%
Switched between MMCP and Original Medicare, but not back again	2,923	29.5%	7,132	77.3%
Started in Original Medicare and joined a MMCP	1,245	12.6%	110	1.2%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	1,678	17.0%	7,022	76.1%
Started in a MMCP or Original Medicare, tried the other and returned to first type	813	8.2%	1,558	16.8%
Started in a MMCP, tried Original Medicare for a time, then back to a MMCP	322	3.2%	36	0.3%
Started in Original Medicare, tried a MMCP (or more than one), went back to Original Medicare	491	5.0%	1,522	16.5%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	9,897	100.0%	9,224	100.0%
Total No. of Medicare Beneficiaries	68,167		63,399	

Source: **CMS Enrollment Data Base, February 2000, March 2001.**

Base: Aged beneficiaries continuously resident in the study site from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP at any time during the study period.

***As of 1/1/01, no MMCPs are available in Sarasota. The data in this table indicate that a few beneficiaries are still listed in the EDB as enrolled in managed care. Some may be enrolled through retiree benefits. Some are listed as still in an exited MMCP. This enrollment may be due to confusion about zip codes and county lines or to recording lags in the EDB.**

****Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

Table B.5
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: Springfield

Patterns of Coverage	July, 1998 - February, 2000* No.	%	July, 1998 - February, 2001 No.	%
Enrolled in same MMCP throughout study period	9,835	64.8%	8,790	59.2%
Switched among MMCPs: started in a MMCP and switched to another (or more)	2,343	15.4%	2,338	15.8%
Switched between MMCP and Original Medicare, but not back again	2,525	16.6%	3,108	20.9%
Started in Original Medicare and joined a MMCP	1,283	8.5%	1,621	10.9%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	1,242	8.2%	1,487	10.0%
Started in a MMCP or Original Medicare, tried the other and returned to first type	466	3.1%	602	4.0%
Started in a MMCP, tried Original Medicare for a time, then back to a MMCP	213	1.4%	301	2.0%
Started in Original Medicare, tried a MMCP (or more than one), went back to Original Medicare	253	1.7%	301	2.0%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	15,169	100.0%	14,838	100.0%
Total No. of Medicare Beneficiaries	55,886		51,919	

Source: **CMS Enrollment Data Base, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP at any time during the study period.
*** Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

Table B.6
Switching Patterns of Aged Beneficiaries Who had Some Managed Care Experience: Tucson

Patterns of Coverage	July, 1998 - February, 2000* No.	%	July, 1998 - February, 2001 No.	%
Enrolled in same MMCP throughout study period	33,668	71.0%	18,660	41.8%
Switched among MMCPs: started in a MMCP and switched to another (or more)	9,676	20.4%	18,734	42.0%
Switched between MMCP and Original Medicare, but not back again	3,645	7.7%	6,155	13.8%
Started in Original Medicare and joined a MMCP	1,901	4.0%	1,984	4.4%
Started in MMCP and switched to Original Medicare, or switched from one MMCP to another and then to Original	1,744	3.7%	4,171	9.4%
Started in a MMCP or Original Medicare, tried the other and returned to first type	429	0.9%	1,050	2.3%
Started in a MMCP, tried Original Medicare for a time, then back to a MMCP	217	0.5%	597	1.3%
Started in Original Medicare, tried a MMCP (or more than one), went back to Original Medicare	212	0.4%	453	1.0%
Total No. of Medicare Beneficiaries with Managed Care Plan experience	47,418	100.0%	44,599	100.0%
Total No. of Medicare Beneficiaries	87,042		80,421	

Source: **CMS Enrollment Data Base, February 2000, March 2001.**
Base: Aged beneficiaries continuously resident in the study site from July 1998 to February 2000, and from July 1998 to January 2001. Includes all beneficiaries who were enrolled in a MMCP at any time during the study period.
*** Data from last year's report, *Medicare Managed Care Markets and Information in Six Communities, 1998-2000,* Abt Associates, June 2000.**

Appendix C

Tables from the NMEP Community Monitoring Survey

Table Appendix C.1
Beneficiaries' Use of Sources of Information about Managed Care: 2001 Survey*
Who did you speak to? Where did printed materials come from?

Sources:	Dayton	Eugene	Olympia	Sarasota	Springfield	Tucson
Managed Care Plans						
- Personal Contact	25.5%	35.6%	29.9%	23.8%	33.9%	45.1%
- Printed information	12.9%	36.6%	35.7%	33.8%	29.6%	48.2%
Insurance Companies						
- Personal Contact	35.7%	38.8%	24.0%	34.3%	32.5%	28.8%
- Printed information	43.0%	28.4%	20.4%	23.7%	27.2%	23.8%
Doctor/Medical Person						
- Personal Contact	18.5%	10.6%	27.7%	13.7%	11.8%	8.7%
- Printed Information	4.3%	2.8%	2.2%	0.4%	2.4%	0.5%
Friend/Family						
- Personal Contact	0.0%	27.9%	17.8%	12.5%	5.9%	10.4%
- Printed information	0.0%	2.8	0.0%	0.4	0.0%	0.0%
Sr. Center, SHIP, etc.						
- Personal Contact	10.2%	0.2%	8.0%	8.5%	17.7%	3.0%
- Printed information	8.6%	19.7%	7.0%	7.4%	9.6%	4.3%
Medicare Office or Helpline						
- Personal Contact	0.0%	3.5%	4.0%	13.7%	0.0%	2.9%
- Printed information	12.9%	14.5%	4.5%	19.1%	10.4%	17.9%
Social Security Admin.						
- Personal Contact	0.0%	3.7%	6.2%	1.2%	0.0%	4.0%
- Printed information	4.3%	3.0%	4.5%	0.4%	2.4%	2.2%
Health Fair						
- Personal Contact	0.0%	3.5%	2.0%	6.9%	3.0%	7.5%
- Printed information	0.0%	0.0%	2.2%	6.1%	5.7%	2.1%
Government						
- Printed information	0.0%	2.8%	13.4%	2.5%	0.0%	9.2%

Source: **Abt Associates Inc. NMEP Community Monitoring Survey of Beneficiaries: January/February 2001.**
Base: All surveyed beneficiaries who sought information about managed care in 2000
***Each survey wave captures information-seeking for the previous year.**

Table C.2
Beneficiaries' Perception of the Usefulness of Information about Managed Care: 2001 Wave*

	Dayton	Eugene	Olympia	Sarasota**	Springfield	Tucson
Those In Original Medicare						
Very Useful	18.3%	33.2%	23.4%	29.4%	41.1%	32.6%
Somewhat Useful	72.6%	50.4%	63.2%	33.5%	29.4%	59.6%
Not Useful	9.1%	16.4%	13.4%	37.1%	29.4%	7.8%
Those in MMCP						
Very Useful	54.6%	51.3%	42.9%	50.6%	48.0%	38.6%
Somewhat Useful	21.1%	39.7%	43.8%	49.4%	48.0%	48.7%
Not Useful	24.3%	9.0%	13.3%	0.0	4.0%	12.6%

Source: **Abt Associates Inc. NMEP Community Monitoring Survey of Beneficiaries: January/February 2001.**
Base: All surveyed beneficiaries who sought information about managed care in 2000.
***The numbers in some cells are quite small. Standard errors ranged from 3.2% to 20.3%.**
****Because both Medicare managed care plans terminated as of 1/1/01, most former MMCP members were enrolled in Original Medicare at the time of our survey. The number of survey respondents recorded as in a MMCP in the EDB is very small.**

Appendix D

Monthly Capitation Rates For Six Study Sites

1998 - 2001

The 2001 rates shown in the tables in this appendix are applicable to March through December 2001, reflecting the BIPA changes. Monthly payment rates in the six study sites were raised to the new minimum payment of $525.00, set for areas in MSAs with a population of more than 250,000.[23] Increases from the initial 2001 rates, which were in effect for January and February 2001, ranged from 2.8% in Sarasota County, Florida, to 21.3% in Lane County, Oregon.

Table D.1
Monthly Capitation Rates, 1998-2001 for Dayton Area Counties

		Aged			Disabled		
County	**Year**	**Part A**	**Part B**	**Total**	**Part A**	**Part B**	**Total**
Montgomery	1998	$273.47	$202.55	$476.02	$216.96	$171.02	$387.98
	1999	$278.55	$206.99	$485.54	$226.84	$168.90	$395.74
	2000	$281.79	$215.46	$497.25	$218.18	$185.90	$404.07
	2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00
Greene	1998	$227.29	$168.34	$395.63	$205.23	$161.77	$367.00
	1999	$231.51	$172.03	$403.54	$214.57	$159.77	$374.34
	2000	$248.37	$189.90	$438.27	$214.10	$182.02	$396.12
	2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00
Clark	1998	$260.44	$192.90	$453.34	$205.23	$161.77	$367.00
	1999	$265.28	$197.13	$462.41	$214.57	$159.77	$374.34
	2000	$276.36	$211.30	$487.66	$214.10	$182.02	$396.12
	2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00
Miami	1998	$242.55	$179.65	$422.20	$205.23	$161.77	$367.00
	1999	$247.06	$183.58	$430.64	$214.57	$159.77	$374.34
	2000	$261.55	$199.99	$461.54	$214.10	$182.02	$396.12
	2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00

Table D.2
Monthly Capitation Rates, 1998-2001 for Eugene, Oregon

	Aged			Disabled		
Year	**Part A**	**Part B**	**Total**	**Part A**	**Part B**	**Total**
1998	$210.84	$156.16	$367.00	$205.23	$161.77	$367.00
1999	$217.91	$161.93	$379.84	$214.57	$159.77	$374.34
2000	$240.40	$183.81	$424.21	$214.10	$182.02	$396.12
2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00

[23] **HCFA, Office of the Actuary, January 4, 2001, memo to Medicare+Choice Organizations and Other Interested Parties. Rates from HCFA.gov.website.**

Table D.3
Monthly Capitation Rates, 1998-2001 for Olympia, Washington

	Aged			Disabled		
Year	**Part A**	**Part B**	**Total**	**Part A**	**Part B**	**Total**
1998	$226.04	$167.42	$393.46	$205.23	$161.77	$367.00
1999	$230.24	$171.09	$401.33	$214/57	$159.77	$374.34
2000	$255.39	$195.28	$450.67	$214.10	$182.02	$396.12
2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00

Table D.4
Monthly Capitation Rates, 1998-2001 for Sarasota, Florida

	Aged			Disabled		
	Part A	**Part B**	**Total**	**Part A**	**Part B**	**Total**
1998	$267.33	$197.99	$465.32	$239.04	$188.43	$427.47
1999	$272.30	$202.33	$474.63	$249.93	$186.09	$436.02
2000	$283.41	$216.69	$500.10	$240.38	$204.36	$444.74
2001	$299.98	$225.02	$525.00	$288.28	$236.72	$525.00

Table D.5
Monthly Capitation Rates, 1998-2001 for Springfield, Massachusetts

	Aged			Disabled		
Year	**Part A**	**Part B**	**Total**	**Part A**	**Part B**	**Total**
1998	$251.18	$186.03	$437.21	$205.23	$161.77	$367.00
1999	$255.84	$190.11	$445.95	$214.57	$159.77	$374.34
2000	$271.79	$207.82	$479.61	$214.10	$182.02	$396.12
2001	$299.98	$225.02	$525.00	$299.98	$225.02	$525.00

Table D.6
Monthly Capitation Rates, 1998-2001 for Tucson, Arizona

	Aged			Disabled		
Year	**Part A**	**Part B**	**Total**	**Part A**	**Part B**	**Total**
1998	$272.04	$201.48	$473.52	$218.57	$172.30	$390.87
1999	$277.10	$205.90	$483.00	$228.50	$170.20	$398.70
2000	$282.81	$216.23	$499.04	$219.80	$186.86	$406.66
2001	$299.98	$225.02	$525.00	$299.98	$225.02	$525.00

Appendix E

Enrollment in Medicare Managed Care in Six Study Sites, by Age Groups: 2000 and 2001

Table E.1
Beneficiary Population and Enrollment in Medicare Managed Care Plans in Six Study Sites, by Age Groups*: 2000 and 2001

	Beneficiary Population		Percent of Beneficiaries in MMCPs	
	2000	**2001**	**2000**	**2001**
Dayton				
<65	20,668	20,339	12.94%	11.53%
65	6,938	7,066	15.32	12.86
66-69	27,020	26,681	21.17	19.25
70-74	32,160	31,495	17.73	17.24
75-79	27,093	26,832	15.89	15.23
80-85	19,601	19,743	13.98	13.67
>85	11,636	11,623	11.73	11.73
Eugene				
<65	5,696	5,856	23.03%	12.41%
65	2,050	2,260	39.37	34.73
66-69	8,547	8,447	46.96	43.76
70-74	10,492	10,319	49.13	48.61
75-79	9,359	9,356	48.09	47.11
80-85	7,246	7,403	48.11	46.72
>85	4,238	4,318	45.94	44.77
Olympia				
<65	3,530	3,703	16.83%	14.07%
65	1,222	1,275	42.80	40.24
66-69	4,704	4,808	51.28	46.76
70-74	5,629	5,701	47.70	46.87
75-79	4,910	4,901	43.05	41.85
80-85	3,871	4,065	42.26	39.66
>85	2,338	2,402	31.48	34.22
Sarasota**				
<65	6,110	6,113	10.92%	1.54%
65	3,836	3,941	10.69	1.17
66-69	16,240	16,022	16.59	1.35
70-74	22,761	22,307	12.63	1.44
75-79	21,111	20,948	10.28	0.91
80-85	16,276	16,839	8.62	0.98
>85	10,105	10,154	5.98	0.92
Springfield				
<65	11,360	11,633	5.92%	4.78%
65	2,792	2,903	22.35	19.05
66-69	11,916	11,619	27.64	27.40
70-74	15,504	15,045	26.11	26.83
75-79	14,333	14,259	24.63	25.23
80-85	11,538	11,759	22.65	23.30
>85	7,174	7,084	15.07	16.69

Table E.1
Beneficiary Population and Enrollment in Medicare Managed Care Plans in Six Study Sites, by Age Groups*: 2000 and 2001

	Beneficiary Population		Percent of Beneficiaries in MMCPs	
	2000	2001	2000	2001
Tucson				
<65	15,704	15,894	35.62%	33.38%
65	5,605	5,805	47.07	37.02
66-69	23,308	23,266	54.75	49.84
70-74	27,989	27,984	53.96	51.27
75-79	24,196	24,068	48.94	47.26
80-85	17,135	17,781	45.04	43.23
>85	9,920	10,130	41.09	39.74

Source: **CMS Enrollment Data Base, February 2000 and March 2001.**

Base: 2000 data: all aged and disabled (except ESRD) beneficiaries living in the study sties in February 2000. 2001 data: all aged and disabled (except ESRD) beneficiaries living in the study sites in February 2001.

***Ages are calculated as of February 1, 2000 and 2001.**

****No Medicare managed care plans are offered in Sarasota County as of 1/1/01. These percentages likely represent those on non-locally offered MMCPs as retirees and some lag in reporting to the EDB. Also, we were informed that at least one departing plan had listed beneficiaries living close to the county line as living in Sarasota County; the error was being corrected in early 2001.**

Appendix F

Information Sources:
CMS Enrollment Data Base and
NMEP Community Monitoring Survey of Beneficiaries

CMS Enrollment Data Base

We used the CMS Enrollment Data Base to track aged beneficiaries who have been continuously resident at our sites since June 1998 to observe their enrollments in Medicare managed care plans (MMCPs) versus Original Medicare. Beneficiaries who have moved into the sites after June 1998, moved out before January 2001, or died between these two dates were excluded. Also excluded were beneficiaries with ESRD (who are not permitted to newly join a managed care plan) and disabled beneficiaries, and those who became newly eligible for Medicare during the study period.[24]

For all tables in Chapter Three that look at enrollment behavior for the full study period, managed care and non-managed care enrollment were identified for each beneficiary at three month intervals, using the first day of each quarter (January, April, July, October), starting with July 1998 up to January 1, 2001. We then added another month of observation by also including February 1, 2001, in order to capture any lags in reporting to the Enrollment Data Base.[25] Beneficiaries who were recorded in the CMS Enrollment Data Base as resident in the sites on the dates we used are identified as "continuously resident." A few tables address a twelve month period, from February 2000 to February 2001 – specifics about the population base for these are provided in table footnotes.

The NMEP Community Monitoring Survey of Beneficiaries

Our NMEP Community Monitoring Survey consists of a telephone interview with beneficiaries in ten sites who were living at home. For this report we used data from the six NMEP case study communities, which have been surveyed from late 1998 to 2001, reporting on information-seeking during the previous twelve months. We excluded several groups, including those whose telephone numbers we could not find, those whose physical or mental impairments prevented telephone interviews, those with ESRD, and non-English speakers. In addition, a pilot administration of the survey yielded extremely low response rates for beneficiaries over 85 years of age. We excluded this age group from all subsequent administrations of the survey, so results generalize only to beneficiaries under the age of 86.

The 2001 sampling design differed in two important respects from earlier years. First, we added a sampling stratum for beneficiaries identified as non-white by CMS files.[26] Second, we added a sampling stratum for "involuntarily disenrolled" beneficiaries in Sarasota, Tucson, and four new sites whose managed care plans had terminated their coverage. As a result, beneficiaries in these over-sampled groups made up a much higher percentage of our sample

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[24] **While the non-ESRD disabled probably have very different managed care enrollment patterns and fewer Medigap options, and therefore warrant study, in our sites there would have been too few in any plan to permit a separate 'switching' analysis.**

[25] **February data are collected from the EDB in March in order to minimize inaccuracies caused by reporting lags. However, it is possible that some reporting lags exceed a month.**

[26] **In all our analyses, we use beneficiaries' self-descriptions to classify race and ethnicity. These sometimes differ from CMS's classification, but most beneficiaries whom CMS identifies as non-white also describe themselves that way.**

than they did of the general beneficiary population. To produce estimates of population percentages, we weighted the data by the inverse of the sampling fraction.

We drew our samples from a complete list of beneficiaries living in each of the study communities. CMS administrative files provided the basis for this information, and we then matched telephone numbers for those who could be found in directories. One third of the beneficiary names and addresses did not yield telephone numbers, sometimes because beneficiaries were in institutions, and therefore not intended to be part of the survey. From 1998 to 2000 response rates ranged from 41 to 54 percent. This year 44 percent of eligible beneficiaries responded in the six study sites. Our total sample size for the 2001 survey was 2,986 beneficiaries, of whom 8 percent were disabled beneficiaries under the age of 65, 55 percent were aged 65-74, and 38 percent were aged 75-85. Total sampling sizes for previous years were 2,349 beneficiaries in 1998, 2,473 beneficiaries in 1999, and 2,382 beneficiaries in 2000.

The survey collected data about the sources beneficiaries turn to for information on Medicare, how well they are aware of, and understand some components of, the Medicare+Choice expansion, whether they need more information than they perceive to be available, whether they received and used the handbook, and their feedback on the handbook. We administered the survey in four waves: in Fall of 1998 (before mailing the handbook), and in the early months of 1999, 2000, and 2001 (after the annual handbook mailings were completed). This approach gathers information on changes in: awareness of some of the Medicare+Choice expansions; where beneficiaries go to find Medicare information; overall rates of information seeking; whether they are aware of the many information resources available to them; perceptions of the handbook; and satisfaction with its information.

Questions that are new to wave 4 of the survey include questions on: how respondents describe their own information-seeking behavior, calls to 1-800-MEDICARE, the plan-comparison section of the handbook, and beneficiaries recognition of the terms "Open enrollment" and "Lock-in."

All survey findings reported in this document as statistically significant are so to the 95 percent confidence level, unless otherwise stated.

For the 2001 survey, we attempted to contact 7,732 beneficiaries in the six sites covered by this report, and eventually obtained completed interviews from 3,041.[27] The contact procedure differed slightly this year from that used in the 2000 survey. In 2000, we terminated attempts to contact 461 (6 percent) of the 7,131 telephone numbers because the survey period ended before we had reached these persons. This year we made 20 attempts to reach every beneficiary. As a result, we contacted 6,112 individuals (79 percent of the telephone numbers selected for the survey). A total of 11 percent of the people we contacted (688) were ineligible for the interview because they were now institutionalized or deceased, or could not be interviewed because of language or other barriers. Assuming that the same proportion of the 1,620 we did not contact would also have been ineligible, we were left with an estimated 6,862 eligible beneficiaries to be interviewed. Of these, 2,383 (35 percent of the estimated eligible respondents) refused the

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[27] **This includes 55 whom we did not further interview because they said they were not on Medicare.**

interview and another 1,438 (21 percent of the estimated eligible respondents) were never contacted. We obtained completed data from the remaining 3,041 (55 of which said they were not on Medicare were not asked the remaining questions). These interviews represent 44 percent of the total number of estimated eligible beneficiaries that we attempted to survey. This is slightly higher than the response rate (41 percent of total attempts) obtained in 2000.[28]

Appendix Table F-1
Response to Survey, by Wave

Survey Outcome	Survey Wave			
	1998 Baseline	1999	2000	2001
Responded	2,520	2,636	2,562	3,041
Not on Medicare	168	163	180	55
Ineligible	522	402	450	688
Refused	2,324	1,747	2,700	2,383
Never reached a person, eligibility unknown	893	478	958	1,620
Overall response rate	*45%*	*54%*	*41%*	*44%*
Overall cooperation rate	*52%*	*60%*	*49%*	*56%*

Source: **Abt Associates Inc.**

***Note: this table includes contacts with persons determined to be ineligible for interview.**

The cooperation rate for 2001 was 56 percent. In each year that we have conducted the survey, minorities and the oldest respondents have been consistently less likely to comply. This continues to be true in 2001. The patterns of cooperation are not significantly different from those of earlier years. In 2001, however, we did stratify the sample according to CMS's records of the beneficiaries' minority status. This allowed us to adjust the data so that minority respondents contribute to the sample estimates in the same proportion as they do to the total population. Thus a small source of bias that was present in the 2000 survey has been removed in 2001. This is unlikely to affect year-to-year comparisons. In 2000, CMS-identified minorities were 3 percent of eligible beneficiaries and 2.5 percent of respondents. Thus correcting for this bias has an effect between zero and ½ percent. In most cases the effect is completely invisible, because minority responses differ by only a small amount from those of other beneficiaries.

[28] **In recalculating the response rates for 2000 we treated the 461 abandoned attempts as though we had attempted to contact the beneficiaries but never reached a person. In earlier years' reports, these abandoned attempts were excluded from the calculations.**